

AD-A195 874

A STUDY TO DETERMINE THE BEST ORGANIZATION FOR A
CLINICAL SUPPORT DIVISIO. (U) ACADEMY OF HEALTH
SCIENCES (ARMY) FORT SAM HOUSTON TX HEALTH C.

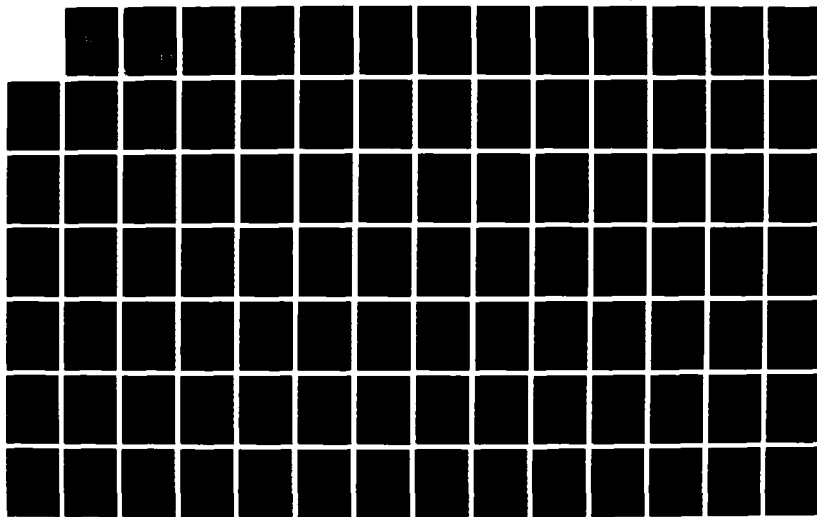
1/2

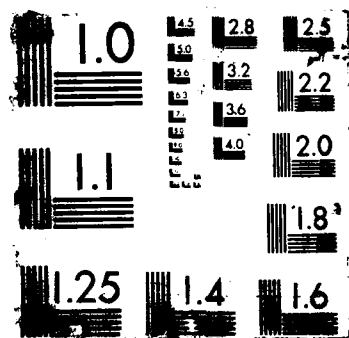
UNCLASSIFIED

T VAN HOOK 01 AUG 81 HCA-8-88

F/G 6/5

NL





AD-A195 874

DTIC FILE COPY

2

A STUDY TO DETERMINE THE BEST ORGANIZATION
FOR A CLINICAL SUPPORT DIVISION AT THE U.S. ARMY
MEDICAL DEPARTMENT ACTIVITY (MEDDAC) FORT ORD, FORT ORD CA.

A Problem Solving Project
Submitted to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree
of
Master of Hospital Administration

By

Captain Thomas Van Hook, ANC

August 1981

DTIC
ELECTE
JUN 03 1988
S D
H

DISTRIBUTION STATEMENT A

Approved for public release;
Distribution Unlimited

00 0 1 00 8

HDA 195 874

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1a. REPORT SECURITY CLASSIFICATION Unclassified			1b. RESTRICTIVE MARKINGS		
2a. SECURITY CLASSIFICATION AUTHORITY			3. DISTRIBUTION/AVAILABILITY OF REPORT Approved for public release; Distribution Unlimited		
2b. DECLASSIFICATION/DOWNGRADING SCHEDULE					
4. PERFORMING ORGANIZATION REPORT NUMBER(S) HCA-8-88			5. MONITORING ORGANIZATION REPORT NUMBER(S)		
6a. NAME OF PERFORMING ORGANIZATION U.S. Army-Baylor University Grad Prog in Hlth Care Admin.		6b. OFFICE SYMBOL (If applicable) HSHA-IHC	7a. NAME OF MONITORING ORGANIZATION		
6c. ADDRESS (City, State, and ZIP Code) Ft Sam Houston TX 78234-6100			7b. ADDRESS (City, State, and ZIP Code)		
8a. NAME OF FUNDING/SPONSORING ORGANIZATION		8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER		
8c. ADDRESS (City, State, and ZIP Code)			10. SOURCE OF FUNDING NUMBERS		
			PROGRAM ELEMENT NO.	PROJECT NO.	TASK NO.
			WORK UNIT ACCESSION NO.		
11. TITLE (Include Security Classification) A STUDY TO DETERMINE THE BEST ORGANIZATION FOR A CLINICAL SUPPORT DIVISION AT THE U.S. ARMY MEDICAL DEPARTMENT ACTIVITY (MEDDAC) FORT ORD, CALIFORNIA.					
12. PERSONAL AUTHOR(S) Thomas Van Hook, CPT, ANC					
13a. TYPE OF REPORT Thesis		13b. TIME COVERED FROM July 1980 TO Aug 81		14. DATE OF REPORT (Year, Month, Day) 1 August 1981	
15. PAGE COUNT 114					
16. SUPPLEMENTARY NOTATION					
17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)		
FIELD	GROUP	SUB-GROUP			
			Health Care, Administration.		
19. ABSTRACT (Continue on reverse if necessary and identify by block number) This study discusses the organization of the present Clinical Support Division, and compares it to the organization mandated by APC Model #18. The author argues that the APC Model #18 is an inefficient organization for large hospitals. He proposes his own organization for the Clinical Support Division, that deviates from APC Model #18.					
20. DISTRIBUTION/AVAILABILITY OF ABSTRACT <input checked="" type="checkbox"/> UNCLASSIFIED/UNLIMITED <input type="checkbox"/> SAME AS RPT. <input type="checkbox"/> DTIC USERS			21. ABSTRACT SECURITY CLASSIFICATION		
22a. NAME OF RESPONSIBLE INDIVIDUAL Lawrence M. Leahy, MAJ, MS			22b. TELEPHONE (Include Area Code) (512) 221-6443/6136		22c. OFFICE SYMBOL HSHA-IHC

TABLE OF CONTENTS

	Page
LIST OF FIGURES.....	III
Chapter	
I. INTRODUCTION.....	1
Conditions Which Prompted the Study.....	1
Problem Statement.....	3
Definitions.....	3
Review of Literature.....	6
II. DISCUSSION.....	34
The Existing System.....	34
Evaluation of the Existing System.....	40
APC Model #18 Clinical Support Division.....	46
Advantages and Disadvantages.....	51
III. AN ALTERNATIVE ORGANIZATION FOR A CSD.....	62
IV. CONCLUSION AND RECOMMENDATIONS.....	75
Conclusion.....	75
Recommendations.....	77
Footnotes.....	78
APPENDIX	
A. Ambulatory Patient Care Model #18.....	82
B. Command Letter Supporting APC Models.....	94
C. Current Organization of the Clinical Support Division	95
D. Decentralized Arrangement of Administrative Assets Prior to 1973 at the USA MEDDAC Fort Ord.....	99
E. Suggested Duties for the Administrative Assistant to the Chief of Professional Services.....	100
F. Suggested Duties for the Chief and Assistant Chief Clinical Support Division.....	100
BIBLIOGRAPHY.....	100



...	99	GRA&I	<input checked="" type="checkbox"/>
		TAB	<input type="checkbox"/>
		ounced	<input type="checkbox"/>
...	100	ication	
...	101	tribution	
...	104	Stability Coles	
		avail. and/or	
		Special	

Dist

A-1

LIST OF FIGURES

Figure	Page
1. "Traditional" Hospital Organization.....	12
2. Liaison Functions of Administrative Assistants.....	14
3. Cook County Hospital Management System.....	21
4. Midland Hospital Center Division Management System.....	21
5. Nursing Personnel in Division Management Role.....	23
6. Decentralized Nursing Management Model.....	23
7. Administrative Matrix Model.....	23
8. Current Organization of the Clinical Support Division.....	34
9. Silas B. Hays Army Community Hospital Organization Chart.....	35
10. Current Requirements, Authorizations, and Assigned to the CSD....	36
11. Relocation of the CSD within the "Professional" Organization.....	62
12. Proposed Organization of the CSD.....	64
13. Proposed Internal Organization and Rating Plan for the CSD.....	65

I. INTRODUCTION

Conditions Which Prompted the Study

In 1977, Health Services Command published Ambulatory Patient Care (APC) Model #18, Clinical Support Division¹, ~~(Appendix A)~~. It suggested grouping all administrative elements which support direct patient care services under a single manager. It further proposed that, to maximize effectiveness, there should be a centralized system of management supervision to provide uniform guidance for all administrative personnel. The purpose of the model was to assist the hospital in establishing an improved administrative management system that would increase physicians' time available for direct patient care.

While APC Model #18 directed itself at administrative management support, the duties and functions proposed for those assigned to this division were much broader in scope. The idea was introduced of also having those assigned to this division provide managerial support to all professional activities. These personnel were to be responsible for planning, organizing, directing, staffing, budgeting, and evaluating the administration of clinical service operations. The management of administrative support was only part of the overall role proposed for those functioning within this division.

The proposals contained in APC Model #18 are not currently required to be totally implemented; the organizational structure can be modified or implemented in part. However, the Clinical Support Division (CSD) concept is being promulgated as the preferred mode for organizing such support services. Various regulations support this concept. It also has the endorsement of top level commanders (Appendix B) and inspectors from higher headquarters evaluate compliance with the recommendations and intent of the APC Models.

>> The U.S. Army Medical Department Activity (MEDDAC) Fort Ord has a Clinical

Cont.
Support Division. ~~(Appendix C)~~ The current organization of the CSD does not
Keywords: Medical Services, Military Medicine. (SDU)
comply with the proposals contained in APC Model #18. The structure, functions,
and duties of the CSD are in some cases significantly different from those
proposed in the model. For example, the Chief, CSD also serves as the admin-
istrative assistant for the Chief of Professional Services(CPS). This is
neither the intent or the recommendation of APC Model #18. This noncompliance
alone generates concern over the appropriateness of the current organization
of the CSD.

Interviews with various managers raised other significant questions
pertaining to the organization and subsequent effectiveness of this division.
A perceived problem existed concerning the lack of role clarity and delineation
of responsibilities for managers within this division. Other perceived
problems included the relationships between the CSD and other "administrative"
staff elements, the arrangement of various functions within the CSD, and the
lack of interaction with the Department of Nursing. The administrative assets
that should or should not be placed in this division and where the division
itself should be placed within the total organization were also considered
to create operational problems that impacted on this division.

In conclusion, knowledgeable managers expressed the opinion that the CSD
is not properly organized in regards to the functions that should be
accomplished. Quality assurance, increased administrative demands introduced by
the Uniform Chart of Accounts, and ever-increasing demands to improve
productivity further complicated what the "proper" organization and role of
the CSD should be. The amount and types of administrative and managerial
demands placed on providers of care are increasing and the CSD is experiencing
significant problems in meeting these demands. A change in the organization of
the CSD is necessary to correct this situation.

Problem Statement

The problem was to determine the best organization for a Clinical Support Division at the U.S. Army Medical Department Activity (MEDDAC) Fort Ord, Fort Ord, California.

Limitations

A number of factors influenced the solutions that could be formulated in this study. One factor, known from the outset, was that since the Clinical Support Division concept is considered at both the command and local level to be a viable approach to meeting some current problems, it was assumed that the complete abolishment of the Clinical Support Division could not be an alternative. The other limitation that arose during the research was the assumption that the current requirements, authorizations, and number assigned to the CSD will not change in the near future. This was based on the fact that projected workload is not expected to significantly increase in the near future.

Definitions

During the course of conducting interviews for this paper it became readily apparent that the term "administrative support" was not commonly defined. Physicians, nurses, those in positions commonly labelled "administrative", and others within the hospital organization defined this term differently. Some attempted to give short, narrow definitions that reflected only their own working situation. Others used vague statements to describe what should be done, not necessarily what was done. The same definitional problems arose for the term "managerial support". Further complicating the matter was the introduction of terms such as "administrative management support" which were used by some in an attempt to describe a role somewhere between what was

considered to be purely administrative or managerial support, yet encompassing elements of both terms.

Most of those interviewed appeared to have only an intuitive concept of the meaning of these terms. Some defined these support functions not from the point of what was to be done, but rather, who in the organization they thought should, or could, perform them. The position, profession, role, and even the rank of those interviewed impacted upon their definition of these terms.

A review of health care literature failed to yield clear, consistent definitions of these terms. The same differences of opinion and attempts to define functions by associating them with established or perceived roles and positions were found. The following is a list of some definitions and descriptions found in the health care literature.

The word "administrative" is defined in the dictionary as "of or relating to administration" ²

"Administration is those activities purposefully undertaken to enhance the rationality of an organization in the achievement of its mission and goals." ³

"The manager's job is getting things done through and with people by enabling them to find as much satisfaction of their needs as utterly possible while at the same time motivating them to achieve both their own objectives and the objectives of the institution. The term administrative is usually used for top management positions, whereas managerial and supervisory usually connote positions within the middle or lower managerial rungs of the institutional hierarchy." ⁴

"Management is achieving objectives through others. Administration is managing the details of executive affairs." ⁵

"Administration is defined as the establishment, control, evaluation and revision of goals, purposes, human resources, programs and systems. Management is defined as the day-to-day operation and implementation of these systems, resources, and programs." ⁶

Administration is used "in the sense of dealing with the internal functioning and supporting services of an organization." ⁷

From the definitions and descriptions listed, it was apparent that common meanings for the terms administration and management were lacking. Many authors

stated that they used the terms administration, administrative, and management interchangeably. Most made little or no effort to differentiate between them.

For the purpose of consistency the following definitions were used:

Administrative procedures: General routine paperwork and other detail procedures associated with the delivery of patient care and/or the internal operations of the work place. Examples would be completing time schedules, assembling patient charts, or making routine appointments.

Professional administrative procedures: Special types of paperwork and other procedures required in the professional delivery of patient care and/or the necessary coordination of functions that are required of the professional to facilitate and expedite such care. Examples would be writing postoperative notes, writing nurses notes, or arranging special diagnostic tests.

Administrative support: That support required to complete administrative procedures.

Managerial support: That support provided by those in positions requiring management training and/or, experience who are tasked with accomplishing functions such as coordinating, integrating, planning, staffing, controlling, budgeting, evaluating performance, and other similar type duties.

Examples would be comptrollers, health care administrators, and head nurses.

Administrative management support: That support given by those who supervise and/or provide operational guidance to those performing administrative support functions and coordinate the assignment of such personnel to work areas.

"Administration": This term is used to generally refer to the aggregate group of managers who are found under the Executive Officer in the MEDDAC organization or under the chief executive officer in the civilian hospital organization.

"Professional": This term refers to the aggregate group of patient care providers under the Chief of Professional Services in the MEDDAC organization.

Review of Literature

The Stimuli and Magnitude of the Problem

A common perception identified in the health care literature was that administrative and/or managerial support for those providing direct patient care was lacking. Reportedly, in some organizations a common complaint from health care providers was that administrative procedures interfered with and even obstructed their work.⁸ Some health care providers stated that nurses spent too much time engaged in low priority tasks. Nurses at some hospitals reportedly spent as much as eighty percent of their time as clerks.⁹ The assignment of secretarial help to perform clerical duties, direct floor traffic, and relieve the nurse of other routine tasks was seen as a method of giving the nurse more time to perform tasks that could not be delegated.¹⁰ Intrinsic job satisfaction for nurses was improved by a reduction in both the variety of tasks performed and the coordinating responsibilities they held.¹¹

Others stated that a midterm solution to the physician shortage was increasing the clerical and other support personnel required in order to free the physician for the full time performance of their professional duties.¹² One physician reflected his opinion on the subject when he titled an article "The New Disease--Administration?"¹³

While the perception of a lack of administrative and/or managerial support was identified in the literature, there was a lack of evidence present to determine the magnitude of the problem. Quantitative determinations of the amount of support lacking and the subsequent impacts on productivity, cost, manpower, and overall organizational efficiency and effectiveness were not identified. The literature consistently arrived at the conclusion that it

was wasteful to oblige patient care providers to perform administrative functions or to manage administrative routines.¹⁴ However, this waste was related only to general increases in wage, opportunity, and social costs. Social costs arose from the fact that when providers performed managerial and administrative tasks, they did not treat patients.

Some authors stated that quantitative determinations of these costs may not be possible. While it was recognized that administrative and managerial demands on the provider's time impacted upon their capacity to produce services, the simultaneous presence of numerous other factors made the singular measurement of these impacts very difficult. These factors included the numbers and varieties of other health care providers and other workers assigned to the work area, types and amounts of equipment used, space, and workflow.¹⁵ Different provider philosophies also impacted on the measurement issue. Studies have demonstrated that the propensity for delegation of tasks to non-physician personnel varies with the type of task and the provider's attitudes toward delegation.¹⁶

A significant problem in attempting to measure these types of support functions is the fact that they are not mutually exclusive in regards to who performs them. Professionals perform certain managerial functions regardless of their official role. Certain professional and legal constraints exist that limit the delegation of some professional duties to the nonprofessionals. However, after these nonprofessionals receive suitable training and/or experience, some of these duties are often delegated to them. Nonprofessionals do perform some tasks that would traditionally be defined as professional. Conversely, for many personal reasons, these professionals retain certain administrative functions. Other functions fall into a "gray area" that do not "fit" in either category. The assignment of these functions vary and some bargaining process

usually determines who does them.

Another cost related to the lack of administrative support to providers definitely cannot be quantitatively measured. This is the dissatisfaction cost of having the provider function without adequate management support, perform administrative procedures, and/or supervise those who provide such support. This cost arises when the provider, whose values are established through the professional socialization process, is forced to deal with the realities of organizational life.

The professional views himself as having unique training, skill, and ability. As such, he perceives himself as a special person who requires considerable control over his work. The concerns of the professional were described as providing services that improve patient care, providing adequate coverage and quick turnaround time for services, and improving the accuracy of results. In addition, the professional works toward improving existing medical procedures and developing new ones as well as keeping up with his education and state-of-the-art developments.¹⁷

Because of these uniquenesses and special concerns, the professional thinks that he must be excused from becoming involved in the ordinary day-to-day routine details of conducting "hospital" business. His concerns center on the benefits of his services to the patient, not the cost of providing them. Administrative and managerial personnel are viewed by the provider as performing very different types of work. They look at costs over benefits. They do the simple, routine jobs that the professional sheds.¹⁸

Studies have demonstrated that individuals oriented toward professional norms are more likely to ignore administrative details.¹⁹ However, when the professional is unable to ignore such details or to shed the tasks he is unwilling to perform, these dissatisfaction costs rise rapidly. This cost is

reflected in increased levels of interpersonal and organizational conflict, high turnover rates, and a possible decrease in overall organizational efficiency and effectiveness.

While the impact of the lack of direct administrative or managerial support has not been measured, the impact of using health care extenders to increase provider productivity has been studied. One such study stated that if physicians were to increase their support staff from the current average of one and one-half aides per physician to an apprent optimum of four aides per physician, productivity could be increased from between thirty and fifty percent.²⁰ These aides provided some type of administrative and managerial support to the physician, however, the impact of such support on either costs or productivity was not identified in these studies.

General Approaches to Resolve the Problem

The fact that administrative duties and certain managerial requirements encroach on the provider's time and that certain costs are the consequence exist almost as an axiom among providers, managers, others in the hospital, and in the health care literature. The problem is what to do about it.

The simplistic approach would be to decrease the administrative procedure workload or increase the amount of administrative and managerial support being provided. The literature clearly demonstrates that the paperwork and non-patient care duties required to operate the modern hospital are continuing to grow. These duties are also becoming more complex. Organizational theory proposes the principle of concentration of specialized labor as a means to maximize efficiency.²¹ This concentration of specialists in the hospital requires a large support network. The presence of specialized departments and a large support network creates new demands for large, comlex administrative

and management systems just to provide "bureaucratic maintenance" of the hospital.²² Administrative procedures and the need for managerial and administrative management support will not decrease. In reality they will probably only increase in the future as hospitals become even more complex; come under closer scrutiny by various groups attempting to control and regulate hospitals; and resources become even more scarce.

The feasibility of simply adding more administrative and/or managerial support personnel to the point where the provider is completely free to perform only those duties which he defines as professional activities is also not realistic. The administrative component increases as the number of places where work is performed increases.²³ The professionals work in numerous locations in the hospital and it would require a very large network of such personnel to insure that the professional provider does not have to deal with such matters. The cost of such a network without the guarantee of significant increases in productivity makes such an idea prohibitive. Such an approach also ignores any benefits of economy of scale or the concentration of specialized administrative and managerial assets. There is an optimal number of support personnel who can provide benefits to the organization. Beyond this point the cost of their employment is not justified by the benefits they produce. The proprietary hospitals readily realize this fact and it contributes to the fact that they have fewer administrative personnel than the non-profit hospitals.²⁴ They also use more staff management specialists in areas such as marketing and labor relations.²⁵ These personnel provide direct and indirect management support to the entire system, not just to select individuals.

If such an approach is selected, clerical personnel could be acquired to accomplish purely administrative procedures. However, it would be much more difficult to acquire and retain managerial personnel unless they were paid

high salaries. The alternative would be to hire less qualified personnel to provide managerial support but this would only complicate the matter. The literature has shown that a basic reason for the lack of rationality in the administration of complex organizations is the lack of properly trained managers.²⁶

The remaining approach is to structure the organization in such a manner that administrative and managerial support can be provided to the professional health care provider in an efficient and effective manner, and yet tempered by the reality of cost and resource constraints. The literature provides few examples of how such goals are achieved in modern hospitals. Figure 1 demonstrates the common "textbook" organizational chart for hospitals that was found in the literature.

The explanation of this "textbook" organization consistently ignored the issue of how administrative support or administrative management support was provided. Discussions of these issues and of subjects such as the costs and benefits of centralization or decentralization of administrative support assets were not found. Most sources simply implied that such support was established and distributed throughout the organization "as needed".

Only one source was located in the literature that discussed the centralized organization and management of administrative support assets. This article discussed the organization of typing and secretarial support under one manager in a Department of Secretarial Services.²⁷ The main objectives accomplished by such a centralized structure were a major cost saving and an increase in available space. Office space was freed by lowering the secretary to physician ratio and grouping certain functions. While this article claimed several benefits, the problems encountered in implementing and operating the centralized organization were not presented.

Some suggestions for the provision of both administrative and managerial

support were identified in the literature. These included the development of professional/administrative positions throughout the organization and the establishment of a network of administrative assistants.²⁸ The literature readily accepted the fact that it would be difficult to find professionals willing and/or able to perform the type of duties that would be assigned to such professional/administrative positions. The cost of such action readily eliminated this role except at the highest levels of management, and even at that level the use of such roles was debated.

The administrative assistant has been, and still is, used by many hospitals. The Hospital Council of Northern California described an administrative assistant as one who "at the direction of superiors conducts special analytical projects in various hospital departments. In a staff capacity, assembles and analyzes data, and reports findings and recommendations to superiors for action. The incumbent is typically, but not always, a recent program graduate."²⁹ The literature did not discuss the number of hospitals or health care organizations that used such assistants but after reviewing various organizational charts it appears that they were frequently utilized.

The impact of using administrative assistants on organizational efficiency and effectiveness was open to debate. Most organizations used these assistants to reduce the administrative procedure workload for one specific person, group, or department. By using the administrative assistant in this manner, certain individuals or groups did receive the support they needed. Other organizations used the administrative assistant to fill management "gaps" that existed within their organization and the role of the assistant depended on the nature of the "gap". However, in many organizations the administrative assistants developed into basically overpaid clerical personnel who performed diverse duties such as

staff studies as directed.³⁰ Their roles were confusing to others in the organization, their duties often were very diffuse and they usually had very limited supervisory roles.

The diffuse nature of this type of role can be seen in a 1966 article which proposed that the administrative assistant become involved in such functions as personnel, purchasing, patient records and reports, arranging travel for those in the department, and coordinating with other departments. In addition, other general administrative duties such as attending meetings, writing policies and procedures, writing letters, and other general duties as assigned fell on the person filling this position.³¹ The administrative assistant was viewed as a "liaison" person who was required to interact with most everyone in the hospital. Figure 2 depicts such a liaison role.

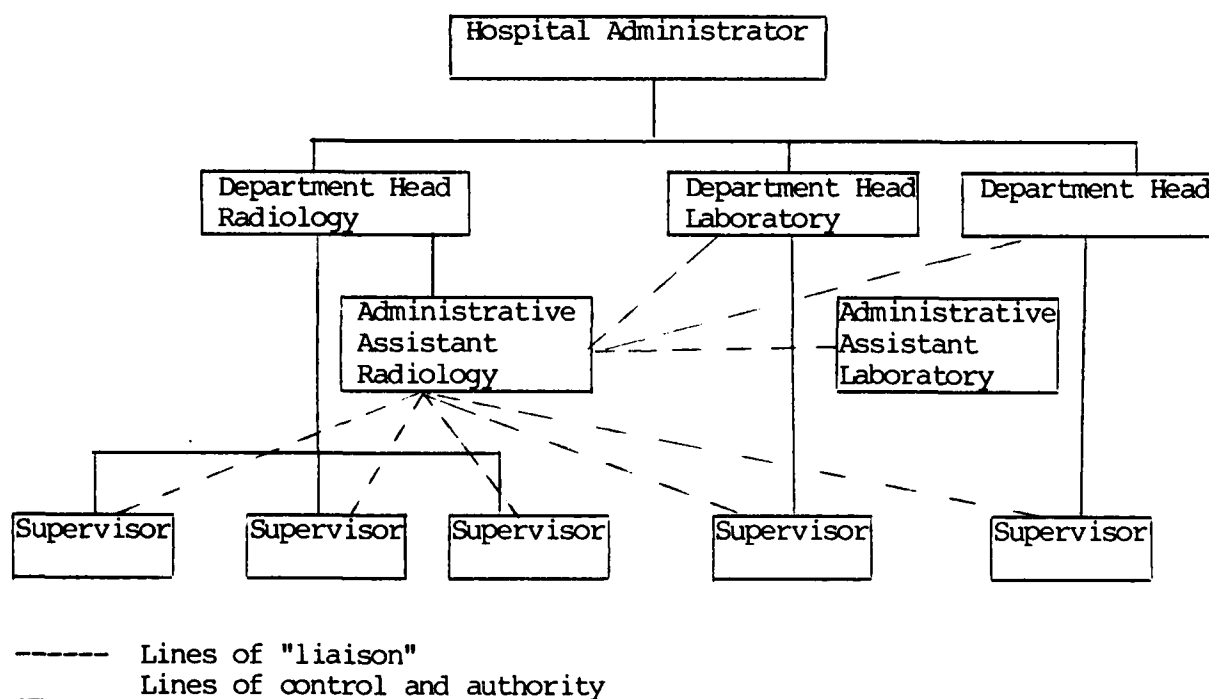


FIGURE 2: Liaison Functions of Administrative Assistants.

SOURCE: Adapted from Hatcil L. Conner, "A New Title on the Administrative Team," Hospitals 107 (September 1976):100.

A common description of the typical administrative assistant was one who "does not have a job that can make a contribution."³² He could not be held accountable for anything and his functions, duties, and objectives were difficult to determine. He was a helper to do whatever his supervisor told him to do, or he did what he thought his "boss" would like him to do. Some authors took a dim view of having a network of such positions in the organization and implied that they should be used only as a last resort.

A variation of the administrative assistant type role was seen in the use of unit managers in many hospitals. These managers were usually found at the nursing unit level and their roles varied according to their training and experience. In some organizations these managers were college graduates and they provided both administrative and managerial support. Other organizations used these personnel in an administrative support role only. In either case, their primary function was to provide direct support to the ward nursing staff.

Other Approaches to the Problem

Organizational structures exist to accomplish two objectives: To facilitate the flow of information in order to reduce uncertainty in decision-making and to achieve effective coordination and integration.³³ A common theme identified in the literature was the need for managerial support to accomplish lateral coordination and integration. This was especially important in the hospital organization with its differentiated departments requiring both coordination and integration to achieve efficiency and effectiveness in operation. In such an organization the use of lateral coordination provides a means of facilitating information flow, integrating the differentiated departments, and facilitating decision making at every level. Various methods of lateral coordination were attempted. Jay R. Galbreth placed them in sequence

by their increasing ability to handle information and cost to the organization as follows. ³⁴

- 1- Direct coordination
- 2- Creation of liaison roles
- 3- Creation of task forces
- 4- Creation of teams
- 5- Creation of integrating roles. This person is not involved in the decision making process and has little or no official power in the organization. His power is derived from others.
- 6- Creating managerial linking roles. This person is involved in the decision making process and has power. Others may work for this manager. They become involved very early in the decision making and planning process.
- 7- Creating matrix organizations.

The first five methods listed have been used for many years. The administrative assistant has been defined as one filling a liaison role and the team concept for providing patient care has long been used in hospitals. Other roles were combinations of the methods listed. The ward manager performed both direct coordination and served in a liaison role. The integrator role, under a variety of titles, has also been established in many hospitals. Highly differentiated organizations have used rules and procedures, appointed liaisons, or built new units into the workflow to serve as the integrating mechanisms.³⁵ Once again, the exact duties and functions performed by those filling such roles differed between hospitals.

The remaining two methods were relatively new and have been the subject of several articles in the hospital literature. They were seen as possible solutions to the coordination problem. These methods are of interest as persons performing in such roles provide managerial support to the professional by relieving him of the burden of coordinating diverse hospital activities.

As has been mentioned in the general literature review, the placement of coordinating responsibilities upon providers had the same impact of encroaching upon their time as having them complete administrative paperwork.

The most common example of the managerial linking role in the "textbook" organization has been through the use of assistant administrators. The Hospital Council of Northern California defined the role of the assistant administrator for support departments as one who "directs, supervises and coordinates the functions and activities of all support departments in the hospital. He develops appropriate objectives, policies, and programs for all functions under his supervision."³⁶ The assistant's responsibilities included such duties as interpreting policies and procedures to those assigned to him and insuring that the procedures developed were compatible with the goals and operations of the specialized departments under their control.

The consistent pattern was to have one executive position with several assistant administrators reporting directly to the executive. In most organizations reviewed the department/division/section chiefs reported directly to the assistant administrator. These chiefs were generally viewed as middle managers responsible for the day-to-day operation of their department and the integration of their department with others in the entire organization. The department chief was responsible for "getting the work done". They also provided administrative and managerial support to their departments and/or had administrative assistants facilitate the accomplishment of such functions. The department chiefs in the "textbook" organization were not physicians. They were managers with a background in the area supervised.

While the position of the assistant administrator was common in the organizations reviewed, the logic for assigning duties and functions to them was unclear. These assistant administrators frequently had responsibility for

diverse departments; there was no ideal form of internal organization.³⁷ While no set rule for the delegation of duties to these assistants existed, many approaches were developed.³⁸ The assistant administrator's functions varied from pure staff to pure line to a combination of both types of functions. The assignment of functions was affected by: the existing span of control, organizational structure, the experience of those who were assigned to that role, the complexity of the department or departments to be managed, the relationship between the departments, the size of the departments, and the overall management philosophy of the trustees and the chief executive of the organization. The intent of using such positions appeared to have been the establishment and provision of administrative and managerial representation and support for each department and to insure that each department "fit" into the organizational hierarchy.

In an effort to determine if support roles similar to those that have been discussed were utilized in other types of health care delivery systems, the current health care literature discussing outpatient and ambulatory care was reviewed. There was a general absence of information and/or examples pertaining to this subject, and a great deal of variance appeared in the organizations evaluated. Some were highly centralized systems with managerial linking roles while others were very decentralized; administrative support was provided "as needed" and managerial support was provided by other managers within a parent organization. The size and type of services provided appeared to have the greatest impact on the internal organization of administrative and managerial assets. This subject was not fully addressed in the literature.

Division and Matrix Management

The use of administrative assistants, assistant administrators, and unit

management systems presented certain problems for the organizations that used them. Among other things, these personnel were filling roles that involved them in multiple functions. They were often expected to perform functions that were not adequately performed by central support departments such as logistics and personnel. They had poor lines of responsibility for support services and they generally suffered from a lack of identity. These problems resulted in a situation where such personnel became "go-fers" for other services.³⁹ The unit managers and the administrative assistants also controlled nothing. In addition, if something "went wrong" it was often very difficult to identify exactly who was at fault. Some assistant administrators shared similar problems. These types of problems created a bureaucratic distance between wards, clinics, and other patient care areas and top level "administration". Central management was not consistently aware of operations at the ward level and problems were not dealt with in a timely, efficient manner.⁴⁰ At the same time, a lack of common purpose was appearing in hospitals which resulted in a lack of compliance with organizational rules, regulations, and procedures.⁴¹ Unit managers, administrative assistants, and some assistant administrators were not in a position to deal with the problems of the complex organization.

Division management was seen as a possible alternative to resolving the problems encountered by using these other types of positions and roles in the hospital organization. This concept was based on the principle that authority to take action should be delegated as close to the point of work as possible. It also was established to clearly let the people responsible for taking certain corrective steps know that they indeed were responsible, and that they had the authority to take actions.

The formation of the division management role attempted to correct other

problems by clearly defining roles, assigning responsibilities, and jointly establishing standards by which effectiveness could be measured. The division manager was to provide decentralized coordination for a set division and he was responsible for controlling certain activities within the established division. Decentralization was seen as a means of giving strength to administration and the organization as it gave strength to the individual parts of the system.⁴² The division manager became a very powerful person. He not only had certain responsibilities, he also had control over those who were tasked with accomplishing the goals and objectives of the division.

Division managers were responsible for providing non-nursing, non-medical support and clerical functions to a given division. Their functions included the supervision of ward clerks, monitoring housekeeping functions, monitoring patient transportation services, and monitoring and assuring the availability of services and supplies from all support departments. In addition, they requested and monitored maintenance services. The division manager also assumed responsibility for functions that were unique to each unit and engaged in activities such as collecting and analyzing data, identifying and communicating problems, suggesting changes, implementing solutions, determining budgets, and developing reporting systems.

The division manager worked very closely with nursing and the medical staff. Such programs consistently formed around the principle of tripartite management, and decisions over assignment of certain duties and responsibilities were agreed upon by nursing, medicine, and administration.⁴³ Joint decision-making on policies, procedures, and functions was the rule, not the exception.

The actual organizational structures for hospitals using this concept varied. Figures 3 and 4 depict two organizations that currently utilize this concept. Figure 3 demonstrates the division management system in use at the

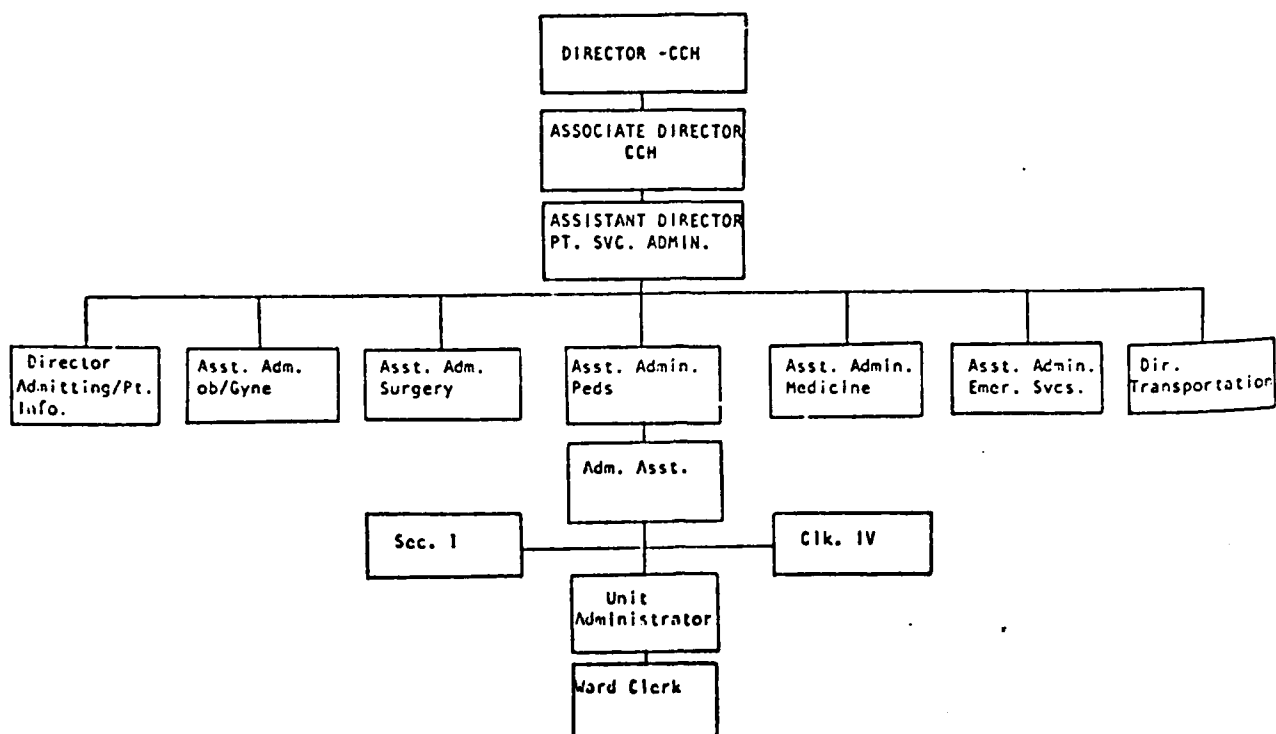


Figure 3. Cook County Hospital Management System

Source: Adapted from Ishwar Gupta, John T. Farrell, Haryash P. Gugnani, "How the Revised Unit Management Program at Cook County Hospital Eliminated 87 Jobs and Saved \$400,000" Hospital Topics 54 (Sep-Oct 1976): 39.

SURGICAL SERVICES DIVISION MANAGEMENT STRUCTURE

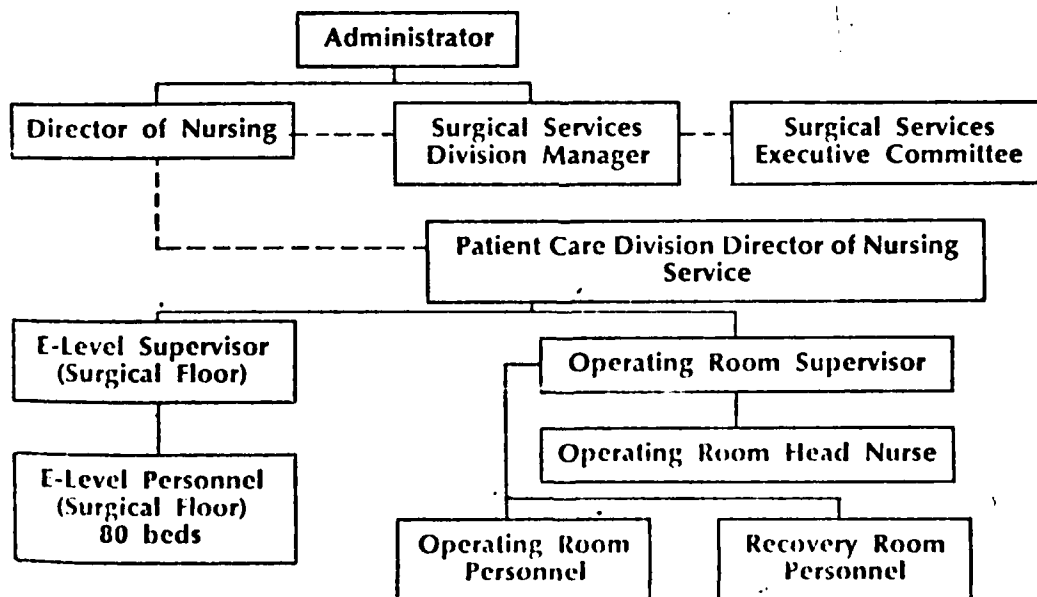


Figure 4. Midland Hospital Center Division Management System

Source: David Reece, Robert Boissoneau, and Eric Wolters, "Division Management System Replaces Unit Management" Hospital Topics 57 (Jan-Feb 79): 15.

Cook County Hospital, Chicago Illinois while Figure 4 demonstrates the division management structure at the Midland Hospital Center in Midland Michigan. The division manager at Cook County Hospital has the title of assistant administrator for a certain service. The division managers are under the Assistant Director for Patient Services Administration. The Midland Hospital Center calls one of their division managers the Surgical Services Division Manager. The figures demonstrate that significant differences in the structures and sizes of such divisions exist. The Cook County Hospital organization is more along "traditional" organizational lines with a structured hierarchy. The Midland Hospital Center organization is much less structured. The number of divisions formed varies with the size and type of hospital. These divisional organizations equate each division with establishing a hospital-within-a-hospital.

Other hospitals use the philosophy of division management but replace the administrative role with a nursing role. Decentralized decision-making authority and accountability are established at the level of the Nursing Patient Services Coordinator who is responsible for both the clinical nursing and administrative aspects for a given area.⁴⁴ Figure 5 depicts such an organization.

A more decentralized model places the head nurse in the role of providing managerial support to a given unit. This approach creates a mini-division manager with the head nurse being the focal point for control and responsibility. While this appears to be contrary to the perceptions discussed in the general review of literature, others see the head nurse as the "logical" person to integrate and coordinate patient care activities and management support.⁴⁵ However, this role is realistic only if ancillary support departments are more responsive and acknowledge that the head nurse is the rational and appropriate person to assess the joint outcomes of all services

Figure 5

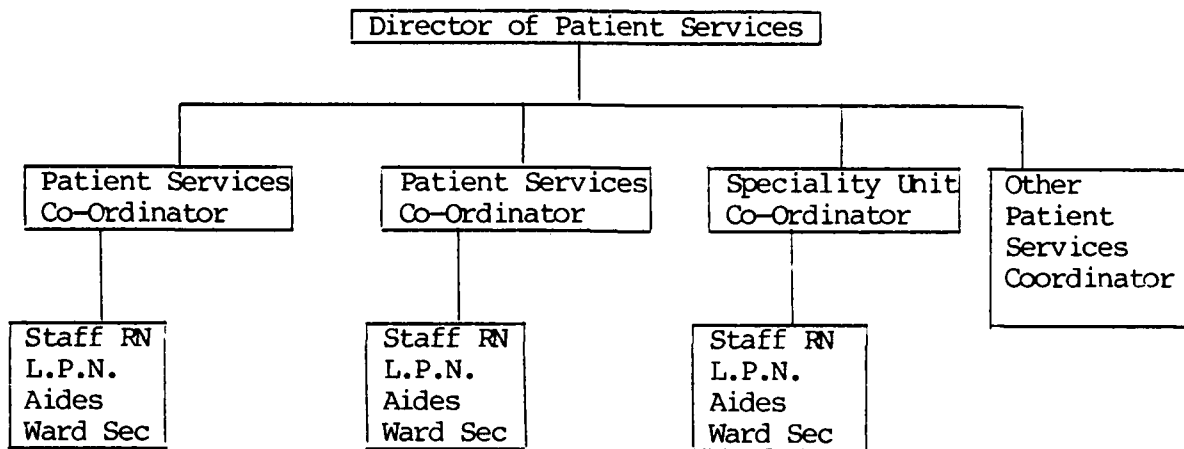


FIGURE 5: Nursing Personnel in Division Management Role

SOURCE: Adapted from Richard R. Rostowsky, "Decentralization: Innovation in Management," Hospital Topics 56 (September/October 1978):15.

converging on the patient. If this occurs the requirements for conflict management consume much less of the nurse's time.⁴⁶ Administrative support is provided by a unit coordinator and a ward secretary who work directly for the head nurse. Figure 6 depicts such a decentralized organization.

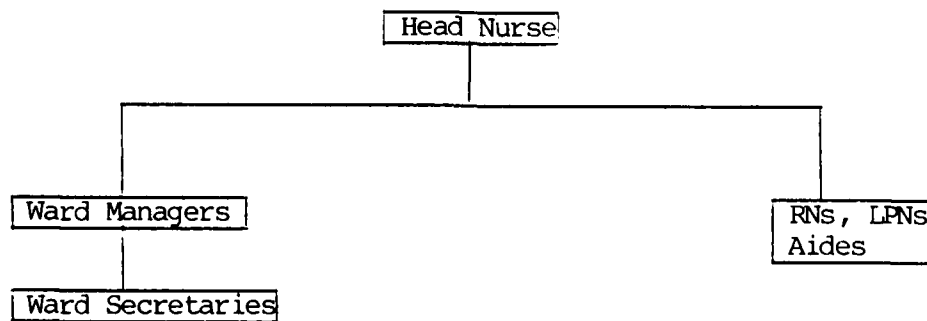


FIGURE 6: Decentralized Nursing Management Model

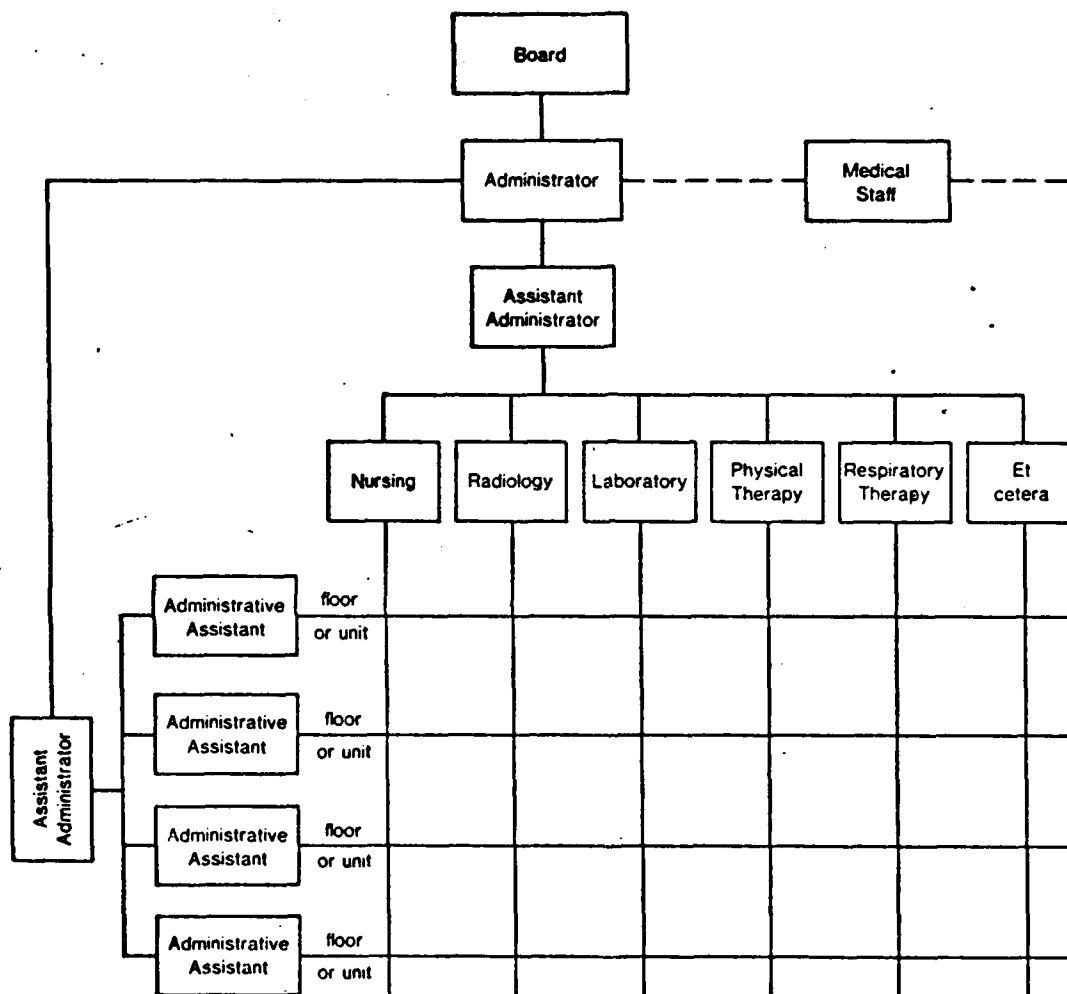
SOURCE: Adapted from Patricia W. Miller, "Open Minds to Old Ideas: A New Look at Reorganization," Nursing Administration Quarterly 3 (Winter 1979): 81.

Another organizational approach established to improve information flow and lateral coordination and integration was the matrix organization. The complex organization was viewed as having too many organizational connections and inter-relations between line and staff elements. Lines of control, communication, and cooperation were too numerous within the formal and informal organization. The hierarchial organization benefited from centralization of specialized resources but this structure was subject to conflicts when the need for multiple projects or teams arose. The problem was how to specialize (create divisions of labor), decrease the numerous lines of communication, control, cooperation, and yet integrate the parts into a whole. Matrix management was seen as a possible solution to these problems.

The matrix structure was intended to meet the need for both vertical and horizontal coordination of specific functions.⁴⁷ This type of organization was seen as being especially appropriate for hospitals since they had a large number of highly differentiated activities that the "traditional" pyramidal organization was unable to coordinate in an expeditious manner and often became overloaded attempting to do so.⁴⁸ In the matrix organization, hierarchial departmentation around the functional specialist was maintained while lateral coordination was also provided through a formal organizational approach. Centralization and decentralization coexisted in this organization and integration and coordination received as much emphasis as specialization.

The expected benefits of this type of organization were the balancing of objectives, sharing of resources, and multidirectional coordination. The major disadvantage reported was the possibility of divided authority and responsibility.⁴⁹ Matrix management violated the unity of command concept for those functioning on the patient care teams. Figure 7 depicts a suggested administrative matrix organization. The people within the matrix clearly shared

ADMINISTRATIVE MATRIX MODEL



--- = Reporting relationships for communication purposes only. There is no direct hire-fire authority.

Figure 7. Administrative Matrix Model

Source: Adapted from Terence F. Moore and Earl Simendinger, "The Matrix Organization: Its Significance to Nursing" Nursing Administration Quarterly 3 (Winter 1979): 27.

their allegiances between the functional chief and the "team" chief who, in the administrative matrix, was part of the administrative hierarchy. Another disadvantage of the matrix was that duplication of efforts could exist between the functional "boss" and the matrix "boss". They could both attempt to perform the same duties in order to arrive at the fulfillment of their own goals. While supporters of this type of model stated that clearly defined roles and responsibilities negate such problems, the fact remains that this organization had problems giving the matrix manager some authority over others who are assigned to, and report to, the functional department chiefs. The literature reviewed consistently presented the philosophical value of the matrix organization, but no evidence was found that indicated that such organizations have actually been formally implemented in hospitals.

It is important to note that there were numerous types of matrix organizations. Some formed the matrix by product produced, project to be done, service provided, or any other situations that required special teams to accomplish. Other types of matrix organizations formed the matrix around people or groups of people instead of what was to be accomplished. The possible combinations of functions that can be formed into a matrix management organization are almost limitless. The main point was that these organizations stressed integration and coordination above control within the organization.

In general terms, matrix models were similar to division management models in that both attempted to create a hospital-within-a-hospital. Division management retained more of a vertical hospital organization while matrix management formed a horizontal hospital-within-a-hospital.⁵⁰ The person representing "administration" (shown on the left of the matrix) was tasked with providing essentially the same types of administrative and managerial support functions as the division manager. The main difference was the philosophical

emphasis of the organization. Division management emphasized control. Matrix management emphasized lateral coordination.

The organizational variations described above agreed on one point. Coordination efforts which are centralized often resulted in a lack of authority, responsibility, and operative coordination at the unit level. The conclusion was that coordinating functions of the hospital must be endowed with managerial rather than mere communicational power.⁵¹

Summary of Civilian Literature

Leonard R. Sayles has observed that there are seven basic elements and responsibilities in administrative roles.⁵² These are:

- 1- To manage workflow- to have operating responsibility.
- 2- To stabilize- to be responsible for approving certain technical decisions before implementation.
- 3- To audit- to be responsible for evaluating performance or decision effectiveness after completion of workflow.
- 4- To advise- to be responsible for providing technical assistance when and if requested.
- 5- To provide services- to be responsible for providing centralized support functions.
- 6- To act as a liaison- to be responsible for acting as an intermediary between managerial and organizational elements.
- 7- To exercise institutional management- to be responsible for personnel and equipment housing and support.

These basic elements were present in different amounts and were distributed differently in every organization. A review of the various organizational designs discussed in the review of literature demonstrated that there was not a

consensus on which of these elements were more important, or what the "proper" combination and organization of these functions should be. The general conclusion noted was that research is needed concerning the advantages and disadvantages of departmental versus unit coordination and various types of arrangements within these categories.⁵³

Administrative and/or management support systems were influenced by the attitudes, opinions, experience, profession, and characteristics of each power group within the organization. There was no consensus on models for analyzing hospital behavior including the reasons that hospitals adopted specific organizational structures.⁵⁴ While some sought to use matrix and other forms of organizations, others felt that the answer to control and integration problems was to simply add more manpower.⁵⁵ The lateral coordination role has not worked well because the persons in these roles lacked knowledge, authority, or both. Articles existed that discussed the issues of delegation of responsibility and accountability but little appeared on the issue of authority or any defined management systems that encompassed all these elements.⁵⁶

The different arrangements for the provision of administrative and managerial support demonstrated that many hospitals have abandoned efforts to establish clear lines of authority, boundary lines, and other approaches that have been accepted as the "proper" methods of organizing. The symmetrical organization with one superior for each subordinate, staff and line functions clearly separated, and unity of management may be a rarity except in only the very small, undifferentiated organization.⁵⁷ The problem was that few realistic alternatives for structuring hospital organizations were provided in the literature. From the amount of reorganization that was reported it did not appear that the right "fit" of administrative and managerial support assets to the needs of the organization had been identified.

Review of Military Literature

The majority of the military literature reviewed was directive in nature and did not discuss organizational alternatives for providing administrative and/or managerial support. It also did not discuss the advantages or disadvantages of the current systems utilized. A review of the general literature did not reveal any published articles pertaining to the CSD concept.

One study of the CSD concept was done in 1980 by three students in the U.S. Army-Baylor Program in Health Care Administration. Their study did not attempt to differentiate between administrative and managerial support as defined in this study. They combined the two under the heading of administrative support.

This study demonstrated that some of the same stimuli present in the civilian sector were also present in the Army health care sector. Of 456 Army health care providers questioned (263 physicians and 193 nurses), 95 percent of the physicians and 88 percent of the nurses indicated that administrative support was valuable to them.⁵⁸ However, 43 percent of the physicians and 41 percent of the nurses perceived that they were limited in the number of patients for whom they were able to care for because of administrative problems, constraints, or requirements.⁵⁹

Several significant findings pertaining to the provision of such support were presented in the study. The preponderance of analysis presented in the 1980 study suggested that, the farther removed from the CSD, the more satisfied the aggregate providers' perceptions became.⁶⁰ A definite proclivity toward decentralized organizations was identified.⁶¹ Of the 34 hospitals surveyed only 13 used the CSD concept established by APC Model #18. The study did not produce evidence that a CSD improved either the efficiency or effectiveness of the hospital. The general conclusion arrived at was that hospitals should

not be directed to comply with the APC Model #18, but rather, they should be allowed to develop organizations that best meet their needs.

Review of Local Military Literature

In an effort to identify local trends and philosophies pertaining to the provision of administrative and managerial support, various local historical documents ranging from 1974 through 1981 were reviewed. In addition, the Manpower Survey Reports (Schedules X) were analyzed.

In 1973 this MEDDAC underwent a reorganization of administrative and managerial assets. This reorganization abolished the position of a clerk supervisor who was responsible for 87 civilian clerks and secretaries. These assets were decentralized under the supervision and control of the department/division/service chiefs or the section NCOICs. In the same year, the Clinical Administration Division was established. It was comprised of an Associate Administrator, Departmental Administrators, and Ancillary Service Point of Contact Coordinators. This organization was intended to intensify the supervisory relationship between the Associate Administrator and the Departmental - Assistant Administrators. The Associate Administrator was given supervisory control over the Departmental Assistant Administrators. He was to provide a source of direction, experience, and expertise for the junior administrators. This single manager concept was to tie all clinical administrative elements together to produce responsive support to physicians and patients and to provide a primary point of contact between the Executive Officer (XO) and all administrative staff officers in all matters relative to clinical administration.

The administrative support services provided by this division were to relieve burdensome administrative requirements from the physician, develop

and implement administrative systems and sub-systems designed to eliminate confusion, and finally to provide education, assistance, guidance, and career development for the junior administrative assistants. This division was to be responsible to both the Chief of Professional Services (CPS) and the XO for planning, organizing, directing, staffing, budgeting, and evaluation of administrative and clinical service operations.

Prior to 1973 administrative and managerial support was provided by administrative assistants assigned throughout the organization. Appendix D demonstrates the distribution of such assets. The changes that occurred in 1973 resulted from the perception that department chiefs were not being given the type or amount of assistance needed. The unsupervised junior officers were seen as having little knowledge or experience in administrative matters. They were also perceived as receiving conflicting guidance, being poorly supervised, not being fully utilized, and in general, producing less than satisfactory results. The department chiefs were described as providing only sporadic direction to these assistants and crisis management was the practice, not the exception. Whether these perceptions were based on fact or assumptions was unclear. No evidence was presented to support these perceptions. Regardless, the single purpose division under one manager was seen as the answer to these problems.

Between 1973 and 1978 several events occurred which impacted on the operation of this division. In 1976 operational control of all medical records was transferred to the Patient Administration Division. During the same period some of the titles within this division changed. The Chief, Ambulatory Support Branch became the Administrator, Department of Primary Care and Community Medicine. Several of the NCOIC positions also changed during this period. In 1977 the Family Practice Service had an administrative officer.

In June 1978, the Clinical Support Division was organized. This formed

an Office of the Chief, Clinical Support Division with five major subsections with each subsection chief reporting directly to the Chief, CSD. These sections were: the Inpatient and Ancillary Support Branch; the Ambulatory Care Support Branch; the Patient Assistance Liaison Officer/Hospital Information; the Medical Library; and the Central Appointment System. The management philosophy of the CSD was to be management by objective and exception.

The Chief, CSD was designated as an Associate Administrator. The Chief, Inpatient and Ancillary Support Branch was to coordinate the administrative support for the Departments of Medicine, Surgery, Radiology, Psychiatry, Nursing, Pathology, and Pharmacy Service. The Chief, Ambulatory Care Support Branch was to provide administrative support to the Departments of Primary Care and Community Medicine and Family Practice. This person was also tasked with providing direct supervision and technical assistance to the Troop Medical Clinics located on post.

The stimuli and philosophies that produced the changes in 1973 promoted the establishment of the CSD in 1978. The only things that really changed in 1978 were the alignment of branches within the division and the addition of certain duties and responsibilities. Several NCOIC positions were realigned and some titles in the CSD changed again. In 1981 the CSD organization was changed again and some titles were again changed (See Appendix C).

In summary, while the philosophy that prompted the establishment of centralized administrative and managerial support did not appear to change, the titles and organizational arrangements of the CSD changed frequently during the period between 1973 and 1981. While some of these changes can be explained due to changes in the overall hospital organization other changes are not as easily justified. In most cases the changes appeared without any rationale or justification.

Summary of Military Literature

The military literature demonstrated that while Army hospitals were being encouraged to adopt the CSD organization the efficacy of such actions could not be clearly established. The Army hospitals appear to have the same types of problems encountered by the civilian sector in that there was a lack of research that established the benefits and costs of the organizational arrangements developed. The constant reorganization discussed also demonstrated that some Army hospitals have done no better than the civilian hospitals at determining what the right organizational "fit" should be between those tasked with providing administrative and managerial support and those providers requiring such support.

Outline of Discussion

The following discussion will describe and analyze the existing organization of the CSD at the Fort Ord MEDDAC. The analysis will be based primarily on interviews conducted at this MEDDAC. The APC Model #18 will then be analyzed using information obtained from the health care literature, interviews with others who have established and/or are assigned to other Army MEDDACS and Medical Centers, and organizational models for CSDs that other MEDDACS have developed. Certain advantages, disadvantages, and questions of efficacy will then be presented in regards to the various organizational models identified in the civilian literature, the current CSD organization, and the APC Model #18. Based on the advantages, disadvantages, and efficacies identified, an alternative organizational model for a CSD will be constructed. In conclusion, the best method of organizing a CSD at this location will be discussed. Recommendations will be presented pertaining to the implementation of this method. Some of those interviewed requested that their anonymity be protected. Consequently, none of those interviewed will be identified in any manner.

II. DISCUSSION

The Existing System

Fort Ord MEDDAC Regulation 10-1⁶² describes the organization and functions of the Clinical Support Division at Silas B. Hays Army Community Hospital. Figure 8 depicts the current organization of this division. Figure 9 demonstrates the placement of this division within the entire hospital organization. Figure 10 presents the current requirements, authorizations, and the number of personnel actually assigned to all elements of this division.

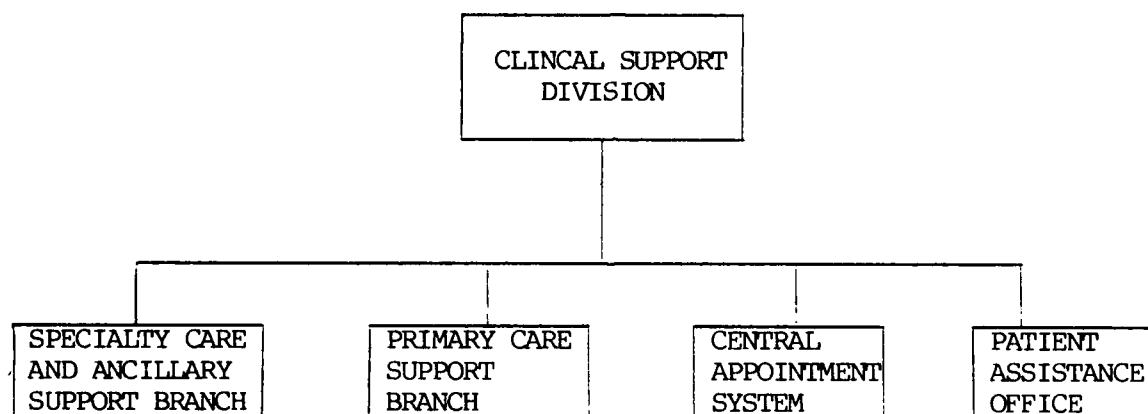


FIGURE 8: Current Organization of the Clinical Support Division.
SOURCE: MEDDAC Reg. 10-1.

Figure 10 shows one Non-Commissioned Officer (NCO) assigned to the Specialty Care and Ancillary Support Branch and another NCO assigned to the Primary Care Support Branch. However, neither is actually working in that branch. The NCO assigned to the Speciality Care and Ancillary Support Branch is actually functioning as an administrative assistant to both the Chief, Professional

CHAPTER 3
SILAS B HAYS ARMY HOSPITAL, FORT ORD, CA

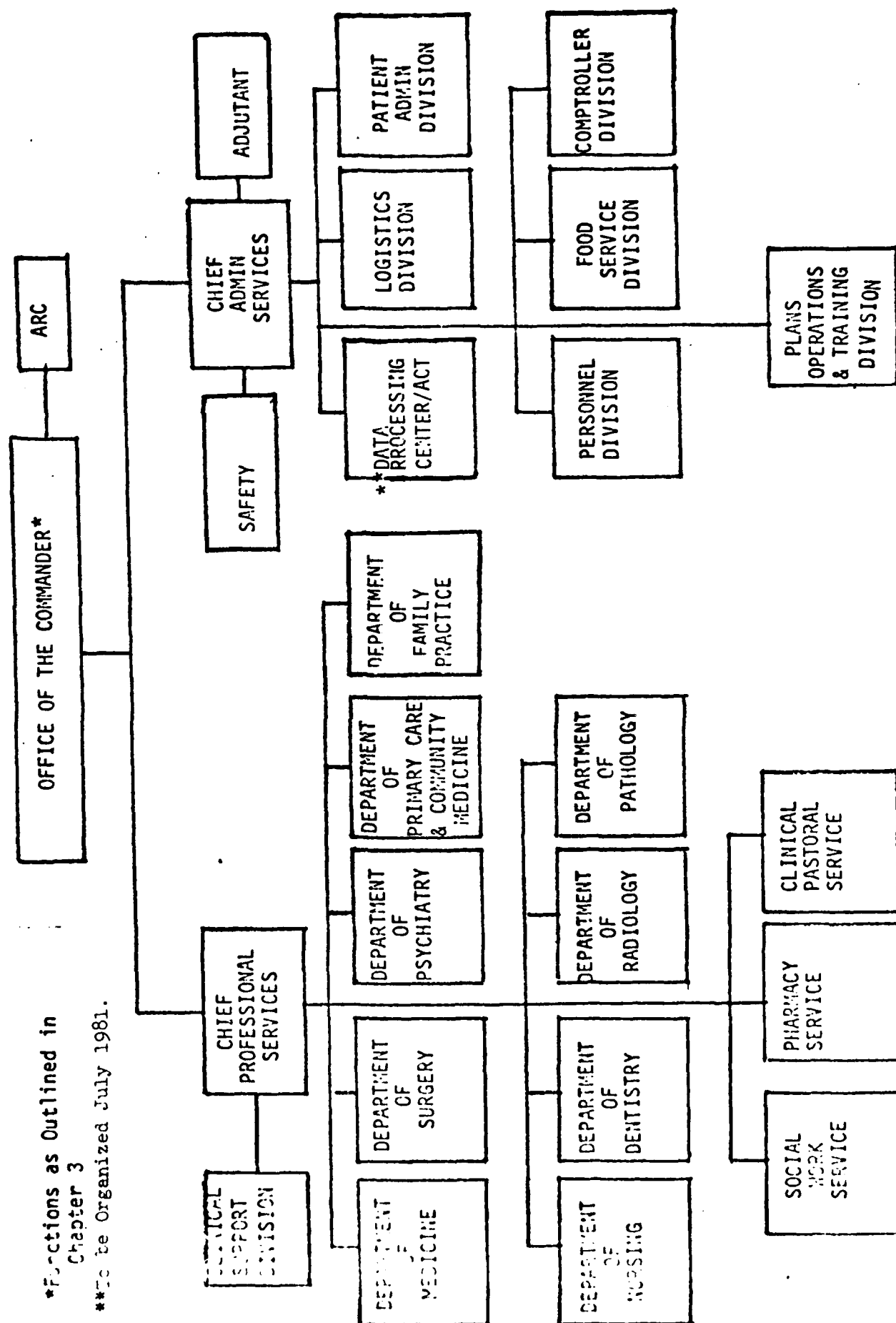


Figure 9. Silas B. Hays Army Community Hospital Organization Chart
Source: MR 10-1

SECTION/REQUIREMENT	AUTHORIZED	ASSIGNED
Office of the Chief CSD		
1 Officer	1	1 (MAJ, MSC)
1 Clerk Steno	1	1
Specialty Care and Ancillary Support Branch		
1 Officer	1	1 (CPT, MSC)
1 Professional SVC NCOIC	1	1 (E-8 71G)
1 Clerk Steno	1	1
2 secretarial positions have been identified as requirements for the Quality Assurance Program (QAP)	2	1
Primary Care Support Branch		
1 Officer	1	1 (1LT, MSC)
1 Senior NCO	1	1 (E-8 91B)
1 Admin NCO	0	0
1 Messenger	1	1
1 Supervisory Medical Clerk	0	0
1 Clerk Steno	1	1
1 Medical Clerk	0	0
Central Appointments		
1 Supervisor	1	1
1 Senior Appointment Clerk	1	1
13 Appointment Clerks	13	11
1 Stat Clerk	1	1
Patient Assistance Office		
1 Patient Assistance Officer	1	1
1 Clerk Steno	1	0

TOTALS: Required-32

Authorized-27 plus
2 for QAP

Assigned-24
plus 1 for QAP

FIGURE 10: Current Requirements, Authorizations, and Assigned for the CSD
SOURCE: Fort Ord MEDDAC Manpower Documents.

Services and the Chief, CSD. In that role he performs duties such as coordination of office activities, maintaining the medical policy program, coordinating various matters with the departmental NCOICs, and other duties to relieve the Chief, CSD, and the CPS of administrative procedure requirements.

The senior NCO assigned to the Primary Care Support Branch has been detailed to provide administrative support directly to the Chief, Department of Primary Care and Community Medicine (DPCCM). In this role he functions as an administrative assistant to the Chief, DPCCM. His duties include coordination of Troop Medical Clinic operations, coordinating various operational matters with the NCOICs of the clinics within the DPCCM, and completing certain records and reports as directed.

If those CSD branches providing specific types of support (Central Appointments and the Patient Assistance Officer) and the two NCOs performing in administrative assistant roles are removed from consideration as personnel available to provide general administrative and managerial support, this division is left with three officers and several clerk stenos. These officers also have other duties which impact on their time available for performing CSD functions. The Chief, CSD is designated as the Associate Administrator for Professional Services. In this role he functions as the administrative assistant for the CPS. His time is divided between this role and being the Chief, CSD. This officer also serves as an Assistant Inspector General (IG) for the hospital and is frequently involved in hearing and resolving complaints.

The Chief, Specialty Care and Ancillary Support Branch also has other duties. He is the coordinator for the MEDDAC Quality Assurance Program (QAP). This officer states that he spends approximately 60 percent of his time dealing with QAP issues, attending meetings, and working on administrative matters associated with this program. Two of the clerk/steno positions listed in

Figure 10 have been designated for the Quality Assurance Program and one is to assume the duties of the QAP coordinator. However, at this time only one of these positions has been filled. These officers also perform the usual rotating duties assigned to all MSC officers in the MEDDAC to include Administrative Officer of the Day, completing Reports of Survey, and investigations.

The functions of those assigned to this division are listed in Appendix C. The functions listed are almost identical to those prescribed by Health Services Command Regulation (HSC Reg) 10-1. The only differences are that the functions of this MEDDAC's Chief, CSD is designated to function as the Associate Administrator for Professional Services and, even though the Chief, Speciality Care and Ancillary Support is presently the QAP coordinator, the Chief, CSD is tasked with coordinating and providing administrative support to the Quality Assurance Program.

The functions of the Chief, Specialty Care and Ancillary Support Branch are the same as those listed in HSC Reg 10-1. The functions of the Chief, Primary Care Support Branch are identical with those functions listed in HSC Reg 10-1 with one major difference. HSC Reg 10-1 states that the functions of this position include the operation of a central appointments system when established. As can be seen in Figure 8 this MEDDAC's Central Appointment System reports directly to the Chief, CSD.

The mission of the CSD is to provide centralized administrative management support to all professional elements of the hospital. However, they have no formal authority or control over any of the administrative support assets in the hospital. Each of the professional departments and services has an NCOIC. The Departments of Medicine and Surgery each have a senior NCO assigned to act as both the NCOIC for the department and the administrative assistant to the department chief. These NCOs are rated and controlled by the department/

service chiefs and their functions include management, supervision, and actual performance of certain administrative procedures within the department/service and to provide assistance to the department/service chiefs in conducting the general operations of the departments and services.

Other personnel are also present who perform certain administrative support functions that are not formally controlled by either the CSD or the department/service NCOICs. These are the Department of Nursing NCOICs assigned to wards, clinics, and Troop Medical Clinics who report to, and are rated by, Department of Nursing personnel. These NCOICs are assigned primarily to supervise the nursing care being provided by other nursing personnel but they also perform certain administrative procedures and become involved in administrative and managerial support in these areas. In addition, head nurses are assigned to all inpatient units and some of the outpatient units such as the Emergency Room and the Family Practice Clinic. These personnel function as health care providers, first line managers for their areas, and they have certain responsibilities for the coordination, integration, and operational functioning of their areas. The Department of Nursing has supervisory personnel in both the inpatient and outpatient areas who supervise, direct, control, and rate these head nurses and NCOs.

It was interesting to note that the wards that are controlled, supervised, and managed by the Dept. of Nursing were viewed differently than the clinics where the same functions are performed. The Medical Service Corps officers interviewed appeared to have the perception that these wards and other specialty care inpatient areas were "off limits" to them. Some stated that they rarely even entered these areas. This "off limits" perception did not apply to the outpatient areas. It appeared that the consensus was that the head nurses and wardmasters were the logical personnel to control and direct

these inpatient and other areas.

The secretaries, clerks, and receptionists throughout the hospital are assigned to specific departments, division, services, or branches. The manner in which they are controlled and rated varies between organizational elements. In some areas the NCOIC rates these personnel while in others, the department or service chief rates them. However, none of these assets are centralized under the control of the CSD as proposed by APC Model #18. The CSD controls only those clerk stenos that are assigned directly to their division.

The Clinical Support Division is physically co-located with the CPS on the second floor of the hospital. The Chief, CSD, the Chief, Specialty Care and Ancillary Support Branch, the NCO acting as the administrative assistant to the CPS and the Chief, CSD, and three clerk stenos are located in four offices directly adjacent to the CPS. The Cental Appointment System is also on the second floor. The Chief, Primary Care Support Branch and the Patient Assistance Office are located on the first floor in the outpatient clinic areas.

Evaluation of the Existing System

From the interviews conducted, the organization and functions of the existing CSD can be summarized in one word: confusing. Those interviewed were not certain what the CSD did, who was designated within the CSD to support them, or what the relationships were between the NCOICS in the various wards, clinics, departments and the CSD. The relationships between those in the CSD and those performing as department and service chiefs was also unclear. Some saw the role of those assigned to the CSD to be "trouble shooters" or "action officers". Others felt that they should prepare award proposals and insure that qualified administrative personnel were assigned to their area.

While confusion was evident, the interviews did not produce comments that indicated an overall displeasure with the administrative support or administrative management support being provided. Many compliments were heard pertaining to the abilities and dedication of those working in the CSD. Several situations were recounted where those in the CSD had provided significant assistance in resolving problems. However, it appeared that most of these interactions had occurred after a significant problem had developed. Little information was provided indicating that proactive management and/or administrative management support activities were consistently initiated by those assigned to the CSD.

A clear consensus of satisfaction or dissatisfaction pertaining to the quality or quantity of support being provided was not present. Those interviewed stated that they valued the support they received and, in general, they recognized the realities of functioning within a system that must operate under certain personnel and cost constraints. One physician stated his perception of the overall situation when he stated that "doctors don't like to do paperwork but it is a fact of life. It is a lot worse on the outside." Those interviewed especially valued the administrative procedure and administrative management support they received from the departmental NCOICs, the Department of Nursing personnel, and the other clerical personnel who were assigned to the departments, services, wards, and clinics. There also appeared to be a general satisfaction with the quantity of such support provided. However, certain comments were made which indicated that a need existed for clerical personnel to function within these areas when the assigned personnel were sick, on leave, or when temporary increases in workloads arose. When such situations arose, the administrative procedure workload was reportedly delayed until the person returned to duty, it was shifted to someone else within the department/service, or the NCOIC did it himself.

The state of confusion referred to appears to exist for several reasons. First, the functions and responsibilities listed in MEDDAC Reg 10-1 for those assigned to the CSD are very ambiguous. Phrases such as "development and operation of appropriate training programs" are almost meaningless. Who is to be trained? Does "operation" mean conducting the actual programs? What does appropriate mean? All the functions listed are open to such questions and the interpretations of these functions varies. The use of terms such as liaison, assistance, and coordination do not lead to clear role definition and uniform understanding of what is to be accomplished.

Second, the organization of the CSD in relation to the other departments/divisions/services is not clearly established or understood. The CSD has no authority over anyone outside their division yet they must maintain close lines of contact and interaction with all departments, especially the department chief and NCOIC. The only authority that those assigned to the CSD have stems from their association with the CPS. While this association produces a certain amount of referent power it also creates relationship problems for the CSD. Many of those interviewed had the perception that all those in the CSD were assigned to, and "worked for" the CPS. They felt that the emphasis on projects and priorities were consistently established by the CPS and that the CSD was one large "assistant to" the CPS. This relationship appeared to impact on the propensity of certain providers to utilize the services of these managers.

The relationship between the CSD and the "administrative" elements of the hospital contribute to this confusion. The managers within these elements appear to want the CSD to become involved in some areas, yet not in others. Clear lines of responsibility and accountability for nonprofessional directives, taskings, and policies, and procedures are not evident. This results in duplication of effort, some organizational conflict, and a perception by some

functional specialists in the "administrative" organization that those in the CSD "have not accomplished anything". Others hold the perception that some managers in the "administrative" organization "dump" on the CSD. This occurs when certain administrative and/or managerial matters are not dealt with in the correct organizational channels. A complaint that was heard was that some administrative procedure and managerial support requirements were sent directly to the departments and services yet, if compliance problems arose the CSD was held responsible. Exactly how the CSD should "fit" into the operations and activities of the "administrative" organization is unclear.

Another problem associated with organizational relationships is that the CSD acts as an additional management level within the "professional" organization. Some of those interviewed questioned the need to informally route certain matters through the CSD before they went to the CPS. The feeling was that certain administrative matters pertained only to specialty areas which those in the CSD would not understand and they would have to be returned for an explanation. Sending such items through the CSD was perceived by some as only slowing the flow of information. Others viewed this additional organizational level as beneficial. Those in the CSD provided a "sounding board" where ideas could be presented before going to the CPS. Exactly how the CSD "fits" into the "professional" organization is unclear.

A third point of confusion arises from the question of who is responsible for coordinating, accomplishing, and/or providing assistance to accomplish unique projects or programs. One professional clearly related that when such projects arise she "wastes time" trying to determine "where to get information, how to organize it, and finding someone with some experience on the subject". She stated that she often needs "someone to help" with such projects that do not naturally align themselves with existing functional experts within the

organization. Others state that they "waste lots of time trying to coordinate things" and that the "lack of coordination causes duplication".

Some of those interviewed associated this need for "someone to help" and for assistance in coordination with the Organizational Effectiveness (OE) role that is used at some Army Medical Centers. The perception was that the OE role provides a non-aligned management resource within the organization that can provide assistance to the first line manager in areas such as problem identification, development of appropriate alternatives, general system design, as well as assistance in evaluating outputs and outcomes. This role was also perceived to offer benefits as the manager would not have to take all their problems to their direct line supervisor. Taking problems to the "boss" opens the manager to possible criticism without assurance that assistance in resolving the problem will be provided. The alternative of having someone to take problems to who is a peer and has the time and knowledge to assist in the problem solving process was appealing to some of those interviewed.

The lack of clear areas of responsibility, authority, and organizational relationships affects the job satisfaction of those assigned to the CSD. The existing confusion results in some instances in the CSD being eliminated from the decision making processes that pertains to administrative management or management support matters. These problems decrease the job satisfaction for those assigned to the CSD.

Another problem identified is that many of the functions performed by the Chief, CSD do not require the attention of a highly trained and experienced officer. Someone else with less education and experience would be better utilized in "pushing paper" which was described as one of the responsibilities associated with current role of the Chief, CSD.

The subdivision of the CSD into an inpatient and outpatient branch creates

other problems for the managers in this division. The functions and support required for these branches is almost identical. Such a subdivision creates redundancies and also requires that each officer have a knowledge in a wide variety of areas. The CSD does not benefit from having each officer develop certain areas of expertise that maximizes the officer's experience, education, and natural abilities. Many of those interviewed viewed the CSD staff as functioning as mini-comptrollers, mini-logisticians, and mini-personnel officers. However, they do not have the functional expertise to fill these roles and thus, they can be accountable for very little.

APC Model #18 Clinical Support Division

The organizational model proposed in APC Model #18 is based on two assumptions. First, if the provider is freed of certain administrative and managerial tasks he will have more time for direct patient care. Second, the most effective way to free the provider of such tasks is to establish a centralized system through which administrative assets can be properly managed, guided, and supervised.

The first assumption as stated can only be partially accepted as true. If the amount of time required to perform one type of task is decreased, then the amount of gross time available for other functions increases. However, the assumption that this additional time will be devoted to patient care is not necessarily true. The provider could use this time just as easily for teaching, studying, or even personal affairs.

The second assumption is open to a great deal of debate. The centralized organization proposed in APC Model #18 complies with the "traditional" principles of organization and management. The span of control appears to be reasonable. Uniform methods of directing and supervising those within the division can be maintained, and the single manager concept may provide more flexibility and responsiveness. At "face value" such an organization should work well. However, centralization is not without costs to the organization. Centralization fixes the organizational level at which decisions are made and it limits the number of groups allowed to participate in the decision making process.⁵⁹ The managers of such centralized systems make decisions pertaining to the utilization of assets that are directly supporting others outside of the centralized systems itself, yet those who depend on the support of these assets may not be invited to participate in the decision making process. Consequently, no one wants to lose control of "their" assets.

APC Model #18 brings to the forefront the issues of control and authority to make certain decisions. Under the concept of the Administrative Support Branch which preceded the CSD concept, the Chief of the Branch was primarily to coordinate administrative and logistical support.⁶⁰ APC Model #18 changes this coordinating role to one that centers on control and authority to direct those within the CSD. In small hospitals, such as the one that the model is based upon, such centralization and control may be feasible. APC Model #18 requires the CSD managers to control a very small number of people: 5 clinic receptionists; 3 ward clerks; and a Central Appointment System with only 5 people assigned. Control over these personnel could be maintained and the needs of those to be supported could be realistically appraised and met. The provision of uniform guidance and supervision of this small number of personnel would also be a fairly simple matter.

As the size of the organization increases the number of such support personnel increases. The single manager's span of control increases and his functions must be delegated to others. The single manager concept breaks down as more delegation is required. In addition, as the organization becomes larger it becomes more differentiated and staff begins to align itself with certain departments. The single manager would have significant problems maintaining control and providing uniform guidance and supervision over such a large number of personnel performing administrative procedures. In a large organization the single manager would also be hard-pressed to determine the real needs of the areas to be supported, determining priorities for the utilization of administrative assets, and resolving the conflicts over the decisions made. The same problems would impact on the managerial support provided. With increasing demands for support who would receive support and what would it be? APC Model #18 does not clearly address these subjects and supports "diluting" the single

manager concept by adding additional levels within the CSD organization as the size of the organization to be supported increases.

To test the efficacy of the centralized model proposed by APC Model #18 information pertaining to the organization of administrative assets was obtained from the MEDDACs at the following locations: Fort Hood, Texas; Fort Polk, Louisiana; Fort Bragg, North Carolina; Fort Benning, Georgia; and Fort Leonard Wood, Missouri. In addition, the same information was obtained from Letterman Army Medical Center, San Francisco CA. and the Landstuhl Army Regional Medical Center, Landstuhl Germany. The assumption was that if the benefits of centralized administrative systems were greater than the costs then such systems should frequently appear in similar organizations.

The results of these evaluations are inconclusive. Some Army CSD organizations are totally decentralized. Some have only a partially centralized organization. Still other CSDs are decentralized. Some have centralized secretarial, clerk typist, and receptionist support while others do not. Only one organization includes centralized support to the Community Mental Health Activity and one organization uses an officer within the CSD for supporting the Troop Medical Clinics.

A continuum from complete centralization to complete decentralization appears to exist with most Army hospitals falling somewhere between the two extremes. Interviews were conducted with personnel at these locations in an attempt to determine why these variations exist. The common theme was that the amount of centralization or decentralization revolved somewhat around local needs but more on the issues of control, responsibility and authority. Those providers responsible and accountable for the outputs and outcomes of certain areas reportedly demand authority and control over the assets which impact upon their operations. This factor appears to be the prime driving force that

determines where on the centralization/decentralization continuum the organizational design falls.

What is more interesting is that most of those interviewed stated that their CSD organizations are undergoing some type of change. Some that were decentralized are moving toward centralization. One organization that had been decentralized, had then gone to the centralized CSD concept, is now moving back toward decentralization. Once again, the struggle over the control of assets, responsibility, and accountability appears to be the driving force. One source made the following comments:

"One of the main drawbacks of this type of system (centralized) is the perception on the part of the clinical staff that things are being taken away from them and that there is a "we-they" syndrome evident in the professional services. They do not have the feeling that they are generally supported for administrative services and that CSD is part of the power structure which some of the clinical staff is distrustful of."

Other variations appear when reviewing the different CSDs. The functions described for those within this division vary significantly. The functions and responsibilities for the Chief, CSD vary in number from five to twenty four. Some appeared to be more oriented toward providing managerial support than purely administrative support. Another difference is the number and rank of the officers and NCOs assigned to the CSD. A consistent staffing pattern is not evident even though the MEDDACs selected for analysis are of similar size and their missions similar. In addition, the utilization of Health Care Administration graduates within the CSD varies between organizations.

It is apparent that a significant amount of variation exists pertaining to methods of organizing a CSD. This would indicate that the assumption presented is false; the benefits of a centralized system do not consistently outweigh the costs, and hospitals have sought different methods of attempting to obtain some of the benefits while minimizing the costs.

Those interviewed locally were also asked who they felt should control and direct those performing direct administrative support (secretaries, ward clerks, and clerk stenos) and those providing administrative management support (departmental NCOICs and wardmasters). The consistent answer was that the department chief should control these assets since he is responsible for the entire operation of the department. These findings support the concept that dissatisfaction with services rise rapidly when the provider of such services becomes involved in a bureaucratic scheme that makes their control more remote, even if the cost to the organization is less.⁶⁴ There appears to be a significant dissatisfaction cost in having certain assets working in an area but controlled and directed by someone else. The results of such dissatisfaction costs appear to be significant organizational conflict which limits the lateral coordination activities of all managers.

The provision of managerial support for the providers of direct patient care is not clearly discussed in the model. The duties and functions addressed in the model clearly establish those in the CSD as providing both administrative management support and managerial support as defined in this paper. However, the model does not attempt to make any distinction between these two types of support. The model does state that the formulation of a mission statement which clearly delineates specific areas of responsibility and commensurate authority are important to the successful implementation of the CSD concept. However, it proceeds to propose vague duties and responsibilities such as providing managerial support to all professional activities. As has been described earlier in this paper, the concept of managerial support is difficult to define and has various meanings. Such vague guidance in these areas does not produce clearly defined local roles and functions.

Advantages and Disadvantages

The preceding discussions have illuminated many advantages and disadvantages of the various systems developed for the provision of administrative and/or managerial support within the hospital organization. As noted, significant arguments can be presented on the efficacy of any one of them. The opinions, attitude, and experience of various sources impacted on whether each point was an advantage, disadvantage, or possibly both.

The following section will address various advantages, disadvantages, and questions of efficacy for the civilian organizational models addressed, the current organization of the CSD, and APC Model #18. The criteria listed below were established to assist in determining advantages or disadvantages. Other points that were identified during the interview process and the review of literature will also be presented. The best organization should:

1. Provide managerial support to the widest number of professional elements, especially to those areas which have little or no direct managerial support assets.
2. Free providers of administrative procedure tasks that could be handled by others.
3. Improve the administrative support and the administrative management support provided to those elements delivering direct patient care services.
4. Support current Army regulations, directives, and/or policies.
5. Insure maximum use of the education and experience of the managers assigned to the organization.
6. Identify and group like functions within the organization.
7. Enhance the job satisfaction of those in the organization.

The Civilian Sector

The civilian literature offers several alternatives to include a network of administrative assistants, the use of assistant administrators, the division management concept, and the matrix organization. The use of administrative assistants frees providers of administrative procedures and the responsibility for providing administrative management support. However, if all managers were utilized in such a manner it would not insure maximum use of their education and experience, and support would be limited to a select few in the organization.

The remaining three approaches offer potential benefits but the efficacy of utilizing them in the Army health care system is questionable. These approaches are utilized in hospitals where the physician is not part of the formal organization and the nursing personnel are basically part of the "administrative" organization; the nursing service is under the hospital administrator. The managers in these systems exist to perform lateral coordination functions and to actively represent top management in the decision making process that has been decentralized to the department, division, or matrix level.

In the Army hospital organizations, these physicians are part of the formal organization. They are department and service chiefs. They also hold significant rank in a system that equates rank with power and authority. The hierarchial organization that is used in Army hospitals is structured to facilitate the vertical flow of information and to actively involve top management with all other levels of management. Lateral coordination is achieved through direct coordination, teams, and occasional task forces. This lateral coordination function is part of every manager's function within the hospital. The integrating function is also part of every manager's function. The department chief integrates all services under his control. The CPS

acts as an integrator for all departments and services within the "professional" organization. Other managers, who also have rank, function on the "administrative" side of the organization. They are also tasked with lateral coordination and integration functions. The XO acts as the integrator for all such departments. The Commander insures that the other integrators and coordinators are, in fact, performing their duties. The Army hospital organization also uses the committee structure to coordinate and integrate certain activities and numerous regulations, policies, and rules exist that formally mandate coordination and integration of certain activities and services.

As the Army hospitals grew and became more complex, the need for lateral coordination increased as did the time needed to accomplish it. Using the physician's time to accomplish routine coordination was identified as wasteful and various liaison roles were established within the ~~organized~~ within the Army hospital organization to assume such coordinating duties. These roles included the administrative assitant, the departmental NCOICs, and the head nurses.

A consistent argument heard during the interviews conducted was that the manager must have authority and control over those who work within their area in order to accomplish the missions and responsibilities assigned to that area. The presence of division managers or matrix managers within an organization such as the Army hospital that already has a formal system of managers delegated with intergrating activities would only complicate the issues of control, authority, and responsibility. The civilian hospitals that use these approaches have fewer managers competing for control over a limited number of assets. They do not exist in a rank conscious system, and their rating systems are flexible.

Division management has been attempted at one Army hospital. The Walter Reed Army Medical Center (WRAMC) uses this organizational approach with the goal of improving both the quality and availability of administration and to increase

the level of medical and nursing services provided to the patient. These division managers have the same type of functions as those described in the civilian literature. Their scope of activities includes acting as the principal resource for the resolution of all types of problems for both patients and staff. It is important to note that WRAMC is constructed in such a manner that each floor is basically a hospital-within-a-hospital which facilitates the division management organization. Each floor contains the inpatient and outpatient services of a department and many of the necessary support services are also co-located on the same floor. One of those interviewed had recently been assigned to WRAMC and her comments did not indicate that this system had achieved a great deal of success in reaching their goals, and the issues of control and responsibility reportedly were not readily resolved by this type of organization.

Attempting to establish a "traditional" hospital organization with it's assistant administrator, a division management organization, or a matrix organization in a large MEDDAC with a limited number of administrative and managerial support personnel would present problems by confusing the lines of authority, control, and responsibility. In a large MEDDAC most of the services are centralized. Inpatient and outpatient services are not co-located and the task of identifying and grouping like functions into divisions to be managed would be difficult. The dissatisfaction costs of using these approaches would be greater than the benefits claimed to be achievable by using these methods of organizing.

The organizations proposed in the civilian literature do propose to maximize the use of the education and experience of those functioning as division or matrix managers and offers some enhancement of the job satisfaction for these managers. However, the conclusion reached is that such models could not be readily adopted in a large MEDDAC without significantly restructuring the entire

organization, the rating schemes, and the orientation of the providers working in it. The civilian hospitals that use these methods appear to have reached a consensus of opinion over who should have control and hold certain responsibilities. As has been stated they did not have physicians and rank to contend with. Current regulations and policies within the military sector do not demonstrate that this sector has achieved the same type of consensus.

While the efficacy of using these models in a large MEDDAC has been questioned there are advantages to be noted. Each of the approaches discussed demonstrated the need for clearly defined roles and responsibilities for those providing either administrative or managerial support. This is congruent with the principle of functional definition.⁶⁶ This principle states that the more a position has a clear definition of results expected, activities to be undertaken, organizational authority delegated, and the authority and informational relationships with others, the more the individual who is responsible for some activity can contribute toward accomplishing the goals of that activity.

The use of formal and informal committees and the tripartite management philosophy for establishing functional definitions for those performing in administrative and managerial support roles indicated that these approaches provided benefits to the organizations. The committee input allowed for joint decision making and goal setting in establishing this functional definition. This supports the idea that "one master is neither improper nor unusual if the servant can get a prompt resolution when the masters disagree".⁶⁷

The civilian literature demonstrated a proclivity towards decentralization. However, most organizations appeared to decentralize only to a certain point where information flow and coordination was facilitated yet, top management could maintain some control over operations. Some balance between centralization and decentralization appeared to be the goal for these organizations.

The Current Organization of the CSD

The organization of the CSD has been described as confusing. The current functions and responsibilities are unclear. There is a lack of authority for those in the CSD and they are perceived as "working for" primarily the CPS. The relationships between the CSD and other organizational elements are unclear and the CSD does not appear to fill the need for "someone to help" when unique programs and projects arise that require managerial and/or administrative support. The current organization and functions of the CSD also does not comply with APC Model #18 which is seen as a disadvantage only from the point of view that this model is the preferred method of organizing such support services.

A significant advantage in the current CSD organization is that it has a strong patient care orientation. As mentioned, the Chief, CSD is an Assistant IG and the Patient Assistance Office also reports to the Chief, CSD. In addition, the close involvement of the CSD with the MEDDAC QAP and other patient care oriented committees contributes to this orientation. The results are that the CSD contributes to health promotion and education programs as they are aware of real patient problems and the problems in the delivery system. This orientation also decreases the "we-they" syndrome for those assigned to the CSD which is embedded in the "professional" organization. Those providers who are knowledgeable of activities of the CSD do not view them as "theys".

Another advantage in the existing system is that the CSD has managed to informally establish lines of communication, coordination, and cooperation with the departmental NCOICs as well as others who provide professional procedure support such as the Patient Administration Division. Although confusion over formal relationships was reported, the CSD has used various informal mechanisms to establish and maintain these lines. As has been stated, CSD personnel conduct informal meetings with the departmental NCOICs on a regular basis and

they attend department and other meetings conducted for those in the "professional" organization. In most cases the confusion reported did not appear to have drastic impacts on the working relationships established between the CSD and these other groups. These informal relationships established a viable method of accomplishing work yet, do not require the department or service chiefs to sacrifice control over their assets. This organization has achieved an adequate level of centralization and decentralization in this area and the physician is being freed of most of the administrative procedure and administrative management requirements.

The disadvantages of the current CSD organization and functions are a result of the problems already discussed. The education and experience of those assigned to the CSD are not being maximally utilized because of the "assistant to" roles performed, and the subdivision of the CSD into an inpatient and outpatient division does not allow for the development of expertise in given areas. These factors, plus those previously discussed, do not enhance the job satisfaction of managers or others in the CSD.

The most significant disadvantage of the current system is that it does not provide managerial support to the widest number of professional elements, especially to those areas which have little or no direct managerial assets. As has been discussed, the organization and functions of this division have evolved over a period of years. However, as it evolved it did not abandon certain missions before it assumed new ones. For example, even though the Chief, Specialty Care and Ancillary Support Branch provides a great deal of support to the QAP, his official functions have not decreased. This type of activity leaves those in the CSD attempting to fill numerous roles with a very limited number of people. The consequence is that certain departments receive less attention than others. As one source stated, the CSD tries to be

"everything to everyone". The CSD is expected to respond to top management, providers, patients, and administration. Managerial support is not uniformly available as others become involved in setting the operational priorities for this division. Areas such as the Department of Nursing and the Community Mental Health Activity receive little or no managerial assistance.

This lack of managerial support will be complicated by future events that will act to both increase the amount of support needed and will present special types of problems that those currently assigned to this MEDDAC will not have the experience or the time to assist the first line manager in resolving. Sometime during the summer of 1981 two computers are going to be installed at this location. One is a Burroughs Model 1955 which will provide general automated data processing support. The other is a Deck 1170 which operates the Computer Stored Ambulatory Records System which will impact primarily on the Departments of Family Practice, Pathology, Nursing, and the Pharmacy Service. The management impacts of these systems are yet to be identified. Most view these systems as offering the potential for improving many aspects of management. However, the literature provides insights that indicate that other impacts may occur as well. Computer systems reduce flexibility, options in decision making, increase the standardization of work, rules, and procedures.⁶⁸ Unexpected problems may also occur. In one study of 40 hospitals, nearly one half had some sort of staff interference toward the system and those involved with it. Most of these incidents involved multiple types of interference to include passive resistance (people would not cooperate), oral defamation, alleged inability to use the system, and actual data sabotage.⁶⁹

Computers also impact on the organization by creating new types of jobs, changing the relative status of certain employees and departments, and changing existing workflows. The change may not occur easily. The MEDDAC will have

personnel assigned to manage computer operations but their services will be taxed maintaining the system itself. Who will assist the first line manager in identifying these types of problems and developing strategies to resolve them?

Other events are occurring which are changing the manager's role. The control of supplies and supply funds is being placed at the activity level where management tools such as daily supply reconciliations are being required. The Uniform Chart of Accounts has generated increased reporting requirements and it supposedly will evolve into a system to assist managers at all levels of management in evaluating the process of health care delivery. It is also to assist in critical decision making and in performance evaluation. However, it will also generate demands and needs beyond what the Comptroller can provide. Who will provide the daily assistance needed?

The MEDDAC QAP and Ambulatory Patient Care Program have both evolved into significant programs at this MEDDAC. After attending numerous meetings associated with both programs it is evident that certain problems and projects arise that do not "fit" into any of the existing "administrative" or "professional" areas. As these programs become more refined the number of such problems that require study and the projects that need completion may increase.

All hospitals have moved beyond simply looking for means to do more; they now look at how to do things better. The civilian hospitals have hired management experts in areas such as finance, marketing, and planning and have placed them in their organization to develop ways of doing things better. The military hospitals must develop means of addressing the questions posed above, plus find ways of also doing things better.

In summary, the current organization does not provide managerial support to the widest number of professional elements, does not identify and group like functions within the organization, does not insure the maximum use of the

education and experience of the managers assigned to this division, and does not enhance the job satisfaction of the managers and others in the CSD. It does provide a certain amount of centralized supervision and direction of the support provided to the elements delivering direct patient care services. While it does not support current directives contained in the APC Program, the organization has been accepted by higher headquarters.

APC Model #18

The evaluation of APC Model #18 presented several points for discussion as to the efficacy of utilizing such a model. From the interviews conducted and organizations evaluated it appears that significant arguments can be formulated on whether the basic issues at hand represent advantages or disadvantages. This model does support current regulations, directives, and policies. It does identify and group like functions. Ideally it improves both the supervision and direction of those providing administrative procedure support and the system for administrative management of these assets. It also claims to free providers of administrative tasks which are handled by those within the CSD. Whether these ends have actually been accomplished is unclear. Those interviewed did not clearly indicate that the provider was actually freed of any more tasks than he was before these assets were centralized within the CSD model proposed by APC Model #18. One reason for this may be the general inability to actually measure such outputs and outcomes. The same types of measurement problems addressed in the civilian literature impact on the ability of the Army hospital organizations to determine if these ends are being reached. The appraisal of the benefits and costs of such a system are purely subjective.

The civilian literature, the existing military literature and the local literature does not indicate that such a centralized system has achieved much success. The civilian literature offered one reference that supported this type of concept but the preponderance of information indicated a propensity toward decentralization. The existing military literature indicates that significant problems exist for those organizations that have used this model and their conclusion did not support the mandatory use of this Model.

The most significant disadvantage of the model, in relation to this discussion, is that it does not adequately address the subject of management support to be provided to those within the "professional" organization. As has been stated, physicians and nurses in the Army hospital organization are managers. As such, they need assistance in the management process to identify problems, develop alternatives, and evaluate systems. Such a role is not clearly identified in APC Model #18 nor does it exist anywhere else in the Army Hospital organization. The model implies that there is a need for this type of function but it does not provide for the functional definition of such a role.

Little evidence can be found to support the idea that this model insures the maximum use of the education and experience of the managers assigned to the CSD or that such an organization and associated functions enhances job satisfaction for those assigned to the CSD. The fact that such a proposed organization may do this is purely an assumption that cannot be supported in either the organizational literature or in military studies. While the intent of APC Model #18 may be desirable to comply with the implementation of the organizational model proposed and its associated functions may present more costs than benefits for the hospital.

III AN ALTERNATIVE ORGANIZATION FOR A CSD

Peter Drucker has stated "the hospital is the most complex human organization we have ever attempted to manage, and, occasionally looking at it, I'm not sure it can be managed".⁷⁰ The preceding discussion of methods for providing administrative and/or managerial support would appear to support such a statement. However, this discussion centers not on how to manage the hospital but rather, how to best support those who do.

Based on the review of literature, the interviews conducted, and the advantages and disadvantages presented for each system a viable alternative will be proposed that incorporates the advantages identified and minimizes the impacts of the disadvantages discussed. This proposal does not suggest creating a new element within the organization but rather, modifies the existing CSD.

The first modification would be to place some organizational distance between the CSD and the CPS. Figure 11 depicts the proposed relocation.

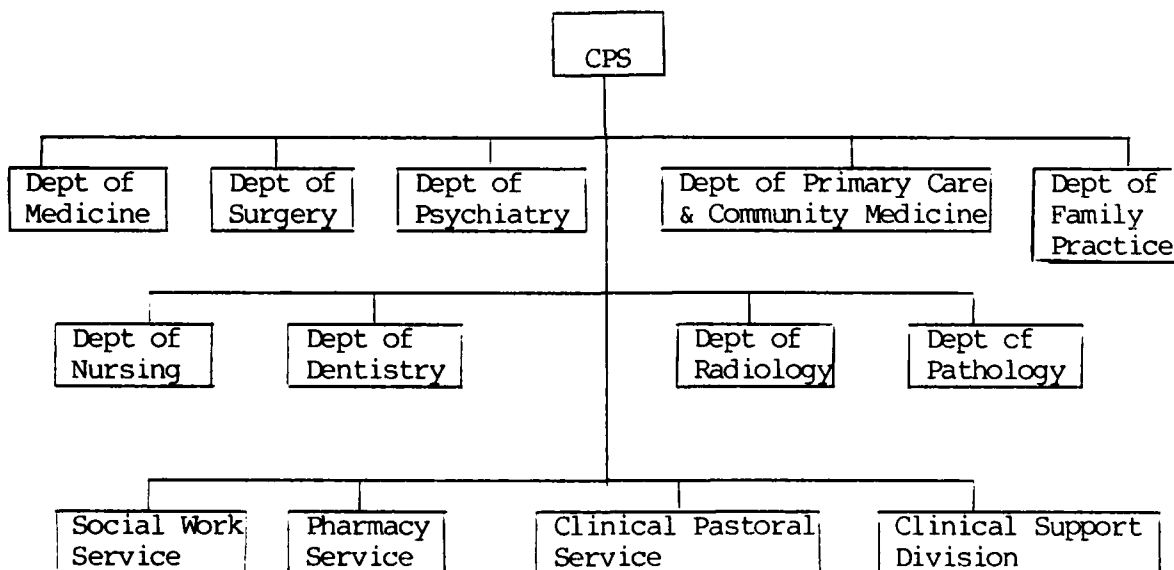


FIGURE 11: Relocation of the CSD Within the "Professional" Organization

As can be seen in Figure 11 this is accomplished by moving the CSD away from the "assistant to" organizational position it currently holds and relocating it in a position aligned with the other departments and services under the CPS. The assignment of the CSD to the position indicated in Figure 10 is an arbitrary decision made by this author; it could be placed anywhere under the CPS.

The internal organization of the CSD would also be modified. The Office of the Chief, CSD, the Specialty Care and Ancillary Support Branch, and the Primary Care Support Branch would be merged into one CSD. Within this CSD the senior of the three officers assigned would be the Chief, CSD. Another would be the Assistant Chief, CSD. The third officer, preferably the junior of the three, would function as the Administrative Assistant to the CPS under the general guidance and supervision of the Chief, CSD. The position of the Patient Liaison Office and the Central Appointment System in relation to the Chief, CSD would not be effected by this change; they would continue to report directly to the Chief, CSD.

The Professional Services NCOIC would be assigned under the direct supervision of the Administrative Assistant and would support both the Administrative Assistant and the CPS. The Administrative Assistant to the CPS and the Prof. Svcs. NCOIC would become the focal points for administrative procedure direction and guidance within the "professional" organization. They would be the source of uniform guidance on such matters. The other senior NCO authorized for the CSD would continue to function as an administrative assistant to the Chief, DPCCM. No modifications to the present organization or assignment of departmental NCOICs, Department of Nursing NCOICs, secretaries, clerk stenos, ward clerks, or any other assets outside the CSD would be made.

The allocation of clerk steno positions within the CSD would be changed to align these assets with the needs of the division. The Chief, CSD and the

Administrative Assistant to the CPS would share one clerk steno and the Assistant Chief, CSD and the Patient Assistance Office would share one clerk steno. The other two clerk stenos would thus be freed to function as "floats" providing administrative procedure support as needed within the "professional" organization. The assignment of these "floats" would be controlled by the Assistant Chief, CSD who would also rate these personnel. Figure 12 depicts the proposed organization for the CSD and Figure 13 demonstrates the proposed internal staffing and rating scheme for the CSD. Note that except for the one clerk steno position currently assigned to the Patient Assistance Office the internal organization and rating scheme for the Patient Assistance Office and the Central Appointment System are unchanged and therefore, not listed on Figure 13.

The physical location of the CSD would not change. The only thing that would change is the office location for these officers. The Administrative Assistant to the CPS would move into the office next to the CPS's secretary where the Chief, CSD is currently located. The Chief, CSD would move to the office where the Chief, Speciality Care and Ancillary Support is currently located and he in turn would move to the first floor into the office currently used by the Chief Primary Care Support Branch.

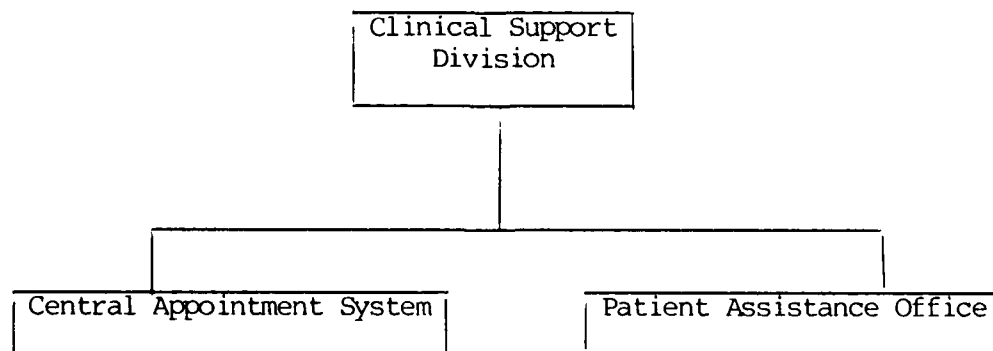


FIGURE 12: Proposed Organization of the CSD.

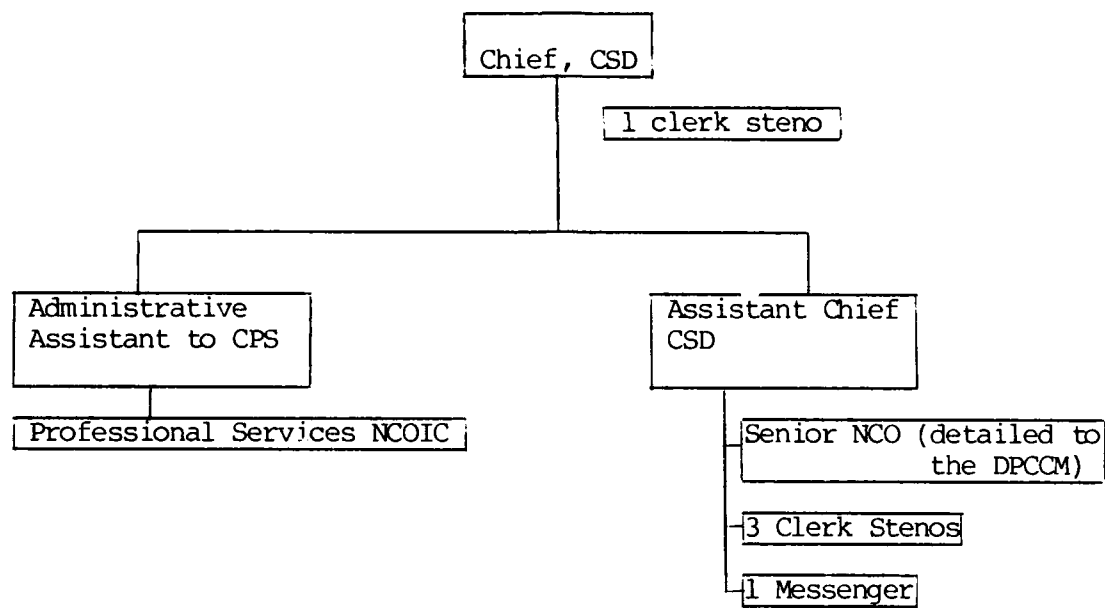


FIGURE 13: Proposed Internal Organization and Rating Plan for the CSD.

As can be noted by comparing Figures 10 and 13 the reorganization of the CSD does not drastically affect the rating scheme for those assigned to the CSD. The CPS continues to rate the Chief, CSD. The Chief, CSD continues to rate and indorse the same military personnel. The two NCOs within the CSD would have a change in rater and the realignment of clerk stenos would impact on the rating scheme for two personnel: The one previously assigned to the Patient Assistance Office and the other previously assigned to the Chief, Primary Care Support Branch. These positions would become the "float" positions under the direction of the Assistant Chief, CSD who would rate these personnel. The current duties of these NCOs would not be altered by this proposal.

This structural reorganization would be accompanied by a significant change in the functions and responsibilities for those officers assigned to the CSD. The Administrative Assistant to the CPS would perform administrative procedure type duties for the CPS. Such duties would include compiling credentials from

physicians and other providers for presentation to the Credentials Committee, assisting in the administrative requirements for the Officer Efficiency Reports and Award Recommendations for the physicians rated by the CPS, and preparing correspondence as directed by the CPS. See Appendix E for a suggested list of tasks to be performed by the Administrative Assistant to the CPS.

The organizational changes would be accompanied by significant changes in the functions and responsibilities for the Chief and Assistant Chief, CSD. Certain functions which are the primary responsibilities of other departments would be deleted. For example, the coordination for timely preparation, completeness, and content of outpatient medical records as a Patient Administration function would be deleted. Other specific functions would remain assigned to the CSD. Examples of such functions would be assisting all those within the "professional" organization in accomplishing their responsibilities in relation to budgeting and the acquisition of capital expense and MEDCASE equipment. Budget planning, coordination, preparation, and supervision for all areas within the "professional" organization would be an example of these types of duties. Another support area that the CSD would be responsible for would include workload auditing for all "professional" elements. These duties would include determining workload in various patient care areas, evaluating workload against capabilities, and coordinating the findings with the department/service chiefs and the MEDDAC Comptroller to identify problem areas and develop alternatives to improve the delivery system. See Appendix F for a suggested list of functions for the Chief and Assistant Chief, CSD.

The CSD would continue to be responsible for providing administrative and managerial support in preparation for JCAH and IG inspections. It would also continue to assist in the implementation of the Ambulatory Patient Care Program within the "professional" organization. The Chief, CSD would continue to

attend all hospital meetings that he currently attends and he would continue to function as an Assistant IG for the MEDDAC.

The type and number of specific support functions would be limited so that time would be available for providing managerial support as needed within the "professional" organization. This support would include administrative management assistance for departmental NCOICs and the assignment of "float" clerk stenos to locations requiring assistance in completing administrative procedure requirements. Managerial support would also include assistance in accomplishing unique projects or problems that arise and/or general assistance needed by anyone in the "professional" organization in areas such as planning, problem solving, or system analysis.

Managerial support missions assumed by the CSD would arise in three basic manners. The first would be projects or problems that would require only a short period of time to complete: one to two days. These missions would be identified by those within the CSD itself, the CPS, department chiefs, others in the "professional" organization, or from the various hospital committees. The Chief, CSD would review all requests for such managerial support and would establish a prioritized listing of projects and problems as well as a tentative schedule for accomplishing these type of missions. The Chief, CSD would maintain a close relationship with the CPS on the nature and number of such support projects as well as the outcomes of the assistance.

The second type of managerial support missions would be major projects that would require more than one or two days to accomplish. The sources of such projects would arise from anywhere within the organization. Such projects or problems for study would be directed to the Executive/Quality Assurance Committee for discussion, prioritization, and assignment as appropriate to the CSD. The Executive/Quality Assurance Committee is a tripartite committee

composed of the Commander, XO, CPS, and the Chief, Department of Nursing and is the primary decision and policy making committee for the MEDDAC. This Committee would be the logical source of such projects since it already receives worksheets on major problems that cannot be resolved at the lower organizational levels and it reviews all minutes from patient care oriented committees. Once a problem or project has been assigned to the CSD they would be responsible for developing a study proposal which would outline how the study would be undertaken. The proposal would be approved by those on the Executive/Quality Assurance Committee before the study actually begins. The CSD would submit progress reports and the final completed study with alternatives described, an optimal feasible solution identified, and recommendations for implementation included to the Executive/Quality Assurance Committee.

The third source of managerial support missions would be those within the "professional" organization that require immediate action. The source of such missions would arise from anywhere within the MEDDAC. The Chief, CSD and the CPS would determine the nature and course of the assistance to be provided.

The assignment of the specific functions and responsibilities listed in Appendix F within the CSD would be determined by the Chief, CSD. The education, experience, and personal skills of the Chief and Assistant Chief would determine which of them would assume the specific duties assigned to the CSD. However, once this delegation is determined the officer who is to perform the function will do so for all departments within the "professional" organization. Close coordination between the Chief and Assistant Chief on the status of various specific functions would be maintained so that when either the Chief or Assistant Chief is on leave, TDY, or absent for other reasons, the other officer could continue to provide this support. The assignment of managerial support missions within the CSD would also be determined by the Chief CSD. Based on

current workload and the nature of the support requested he could retain the project, assign it to the Assistant Chief, or both officers could complete the project.

These changes in organization and responsibilities would be formalized by publishing a change to MR 10-1. This change would describe the modified organization and establish functional definition for the roles and responsibilities to be assumed by those officers assigned to the CSD.

The CSD has been structured in this manner for several reasons. Modifying the present location for the CSD within the "professional" organization will reduce some of the confusion that has been reported pertaining to the "assistant to" role of the CSD. The previous position of the CSD made it appear as though it was in fact an "assistant to" for only the CPS. Moving the CSD establishes it as a legitimized organizational element. This movement, along with the clarification of responsibilities, also eliminates the CSD as an additional organizational level between the departments and services and the CSD. Documents and information would not routinely be routed through the CSD before going to the CPS. However, the departments and services still have the option of utilizing the CSD as a "sounding board" for ideas and plans before they are presented to the CPS.

This deletion of the additional organizational level also prevents certain administrative procedure and policy matters from "getting out of the right channels". Those matters that do not fall within the specific support functions of the CSD would not be routed through this division to others within the "professional" organization. In addition, the CSD could not be held responsible for noncompliance in areas that they are not specifically tasked to perform; others could not "dump" on the CSD.

Figure 11 demonstrates that the CSD continues to be placed under the

direction of the CPS. A great deal of debate can be identified as to whether the CSD should be under the XO or the CPS. Under this proposed alternative the CPS is felt to be the appropriate person to direct and rate CSD activities since he is responsible for all activities within the "professional" organization. In addition, the CSD needs to retain some referent power from the CPS in order to function. Returning to the "we-they" syndrome, the CSD is considered to be a "we" in the "professional" organization. Placing them under the "administrative" organization could foster the impression that the CSD is a "they" limiting the effectiveness of the managerial support to be provided.

The modification of the internal organization of the CSD would accomplish several goals. The assignment of a company grade officer to function as the Administrative Assistant to the CPS frees the Chief, CSD to perform those duties and responsibilities of the CSD. This move continues to free the CPS of administrative procedure tasks, yet would provides maximum use of the education and experience of all officers assigned to this division. The combination of the Primary Care Support Branch and the Speciality Care and Ancillary Support Branch into a single CSD eliminates redundancies in the existing support branches and would allow the assigned officers to develop certain areas of expertise in the areas that they are responsible for. In addition, the CSD will be able to continue to provide support for each department/service even if one of the officers within the CSD is on leave, TDY, or absent from duty for any reason. This action also reduces some of the confusion over which officer supports certain sections. Certain officers do not support specific departments and services; the CSD supports them all. Those requiring assistance would no longer need to seek out the one officer tasked with supporting their department as both officers would be involved in supporting all departments and services within the "professional" organization.

The Administrative Assistant is retained under the Chief, CSD so that administrative and managerial guidance can be provided to this officer from a trained and experienced manager. The Professional Services NCOIC is placed under the Administrative Assistant as the amount of administrative procedure workload generated through the CPS requires two persons to complete. One person would have difficulties in accomplishing both the type and amounts of workload generated. This alignment also improves the flow of administrative guidance and direction from the CPS to the department chiefs and NCOICs. Information would flow from the CPS through the Administrative Assistant and the Prof. Svcs. NCOIC to the department chiefs and NCOICs.

Retaining the current organizational assignment and responsibilities for the other CSD NCO, departmental NCOICs, secretaries, typists, and clerk stenos assigned to the departments and services prevents conflicts over the control of such assets, yet allows for some centralized guidance and direction to be given to these personnel. As has been stated, the interviews conducted did not indicate that the amount or quality of administrative task accomplishment or administrative management support was significantly lacking. The working relationship that has been established between the CSD and the departments and services appears to be functional. The proposed alternative would not change these relationships but rather, they would be significantly strengthened. The informal meetings currently held would continue on a regular basis. The Prof. Svcs NCOIC would attend to discuss administrative procedure management while the Chief or Assistant Chief, CSD would discuss specific activities pertaining to their support responsibilities, administrative management support topics, and general managerial support needs and activities. In addition the use of "float" clerk stenos would improve the quantity of administrative procedure support personnel available within the "professional" organization. These personnel

would replace departmental administrative assets when they are absent from duty. These "float" administrative procedure support assets would be under the control of the Assistant Chief, CSD because the determination of the need for such support and the prioritization of these needs falls within the management realm of the CSD and not within the administrative procedure realm of the Administrative Assistant or Prof. Svcs. NCOIC supporting the CPS.

The advocates of division management and APC Model #18 would argue that such an approach does not insure uniform guidance and supervision of administrative procedure assets. In a large MEDDAC, such as Fort Ord, the single manager is unable to provide uniform supervision for such a large number of assets. The use of the NCOIC positions to supervise these decentralized assets and the use of the Administrative Assistant and the Prof. Svcs. NCOIC to input uniform guidance on administrative procedure matters to the other NCOICs would not decrease the quality of the supervision currently provided. This proposal requires some providers to rate these support assets but the cost of this action is less than the dissatisfaction cost of losing "their" support personnel.

The most significant benefit of the proposed alternative is that the CSD will now improve the managerial support provided to all those within the "professional" organization plus the Community Mental Health Activity. This support not only meets current needs but it also establishes a system for the provision of managerial support in the future as unique problems and projects arise. The officers assigned to the CSD become the "someone to help" in the accomplishment of special projects and programs that arise within the "professional" organization but do not fall within the functional expertise of others in the hospital. This role maximizes the education and experience of the officers assigned to the CSD and enhances the overall job satisfaction of those assigned to this division. This role also allows those within the

"professional" organization the opportunity to discuss operational problems with someone within the organization who is not their first line supervisor.

There are many types of coordination to include corrective, preventive, regulatory, and promotive.⁷¹ Promotive coordination involves those activities which attempt to improve organizations and the articulation of parts of various systems. It attempts to develop better ways of doing things. The high use of promotive and preventive coordination is positively related to efficiency and quality of care.⁷² Most managers and supervisors are too involved in corrective, regulatory, and preventive coordination to do very much promotive activity. The strong managerial support role proposed for those officers within the CSD would establish a focus for promotive coordination within the "professional" organization and provide a resource to aide others in developing skills in this area.

Those managers assigned to the CSD are the ideal persons to accomplish this promotive coordination and general managerial support role. Their fixed support functions give them wide contacts throughout the organization and the modified organizational position proposed will not make them appear to be partial to any one perspective or group. In addition, if health care graduates continue to be assigned to CSD positions, their previous training and experience enables them to begin to understand the professionals. They can exert influence on a basis of expertise and not through formal power and they have been exposed to conflict management skills to assist them in their activities. They have also been trained to perform systems analysis studies and are familiar with many other management techniques.

The use of certain fixed support functions as proposed allows those in the CSD to provide assistance in certain critical areas and it provides targets of opportunity for these managers. These targets of opportunity allow the

the CSD managers to interact with all departments on a regular basis which provides interaction with the department and service chiefs and NCOICs. In doing so, the CSD managers establish themselves as an asset to these first line managers and the opportunity exists to suggest other areas where assistance can be provided. These specific functions allow the CSD managers to move from a peripheral role to one where their support can be identified and utilized by these first line managers.

These specific support functions for the CSD will also have other benefits for the organization. The NCOICs are functioning as managers. They prepare the budget for their areas, determine MEDCASE and capital equipment needs, and they supervise their personnel. The specific functions addressed do not act to usurp the functions of these other managers. These functions assist others in performing these tasks while at the same time, insures that the tasks are completed in accordance with current regulations, policies, and directives. Those who experience significant problems in these areas, or in any area of management, can avail themselves of the managerial support provided by the CSD. These functions allow these NCOICs to perform as managers. The managerial support provided will also assist them in finding better ways of doing their jobs and will help them become better managers. These actions will enhance the NCOICs job satisfaction and subsequent duty performance.

The use of a tripartite committee to assign certain projects and problems for resolution to the CSD will act to gain organizational consensus for their activities. This approach allows for joint decision making and goal setting over the roles and responsibilities of the CSD. The relationship between the CSD and this committee will also improve the QAP as it will provide qualified personnel to study and resolve problems that arise within this area.

IV CONCLUSIONS AND RECOMMENDATIONS

Conclusion

The preceeding discussion presented several different methods for providing administrative and managerial support to the providers of direct patient care. Each had a different emphasis and focal person (or persons) to achieve such support. They also had different advantages, disadvantages, and questions of efficacy pertaining to their use in the Army hospital organization.

The interviews conducted, documents reviewed, and literature studied demonstrated that there was no consensus of opinion on the "proper" method for organizing those performing administrative procedure tasks for the provider. In addition, a consensus of opinion on the optimal method of providing administrative management or managerial support could not be located. These subjects were fraught with personal opinions, intuitive concepts, past experiences, wishful thinking, and good guesses. The ultimate decision of what is "proper" appeared to rest with those who held the most power in the system.

There is a lack of clear guidance on the organization of administrative procedure, administrative, and managerial support assets within the hospital organization. There is also a lack of published research to facilitate decision making in this area. The decision maker is faced with several alternatives to include retaining the current CSD organization, adopting the centralized organization proposed in APC Model #18, selecting the alternative proposed in this study, or attempting to use one of the methods addressed in the civilian literature. Each has certain benefits and costs for the organization.

The alternative proposed in this study for organizing a CSD builds on the advantages and disadvantages noted for the other organizational methods that

were presented. It is concluded that this is the best method for organizing the CSD as it provides the greatest number of benefits without incurring significant costs. This proposed organization for a CSD provides managerial support to the widest number of professional elements, especially to those areas which have little or no direct managerial support assets. It builds on a system that already frees providers of administrative procedure tasks and has a system for providing supervision and direction of administrative support elements. It supports current regulations, directives, and policies and identifies and groups like functions within the CSD. Finally, it insures the maximum use of the education and experience of the managers assigned to the CSD and it enhances job satisfaction for these personnel as well as the satisfaction of others in the organization. It also maintains a strong patient care orientation, improves the MEDDAC QAP, and provides a mechanism for not only meeting current needs but also future managerial demands that will be placed on the provider. All this is accomplished while avoiding the dissatisfaction cost of centralizing these assets.

While the proposed organization for a CSD does not comply with APC Model #18 this discussion has illuminated several reasons why such noncompliance is justified. Although APC Model #18 is supported at the major command level there is adequate evidence to question the basic efficacy of this support for large MEDDACs such as Fort Ord. APC Model #18 and the other methods described do not allow the organization to seek out new ways of doing things better. The proposed organization for a CSD addressed in this study allows the organization to seek out better ways of doing things at many levels within the organization and this approach will provide many more opportunities to improve the health care delivery system, improve productivity, and to improve overall organizational efficiency and effectiveness.

Recommendations

This study was conducted to determine the best organization for a Clinical Support Division at the U.S. Army Medical Department Activity (MEDDAC) Fort Ord. The following recommendations are made as a result of this study:

1. The alternative organization for a CSD developed in Chapter III be adopted by this MEDDAC.
2. That an ad hoc committee be formed to discuss and approve the specific support functions to be accomplished by the CSD. This will gain organizational consensus for the functions of the CSD and will assist in establishing clear, concise, understandable duties and responsibilities for those in this division.
3. After the specific support functions are determined the CSD publish a change to MR 10-1 establishing their specific support and managerial support functions as well as the mechanics for obtaining managerial support from the CSD as established in the proposed organizational alternative presented in Chapter III of this study.
4. That a formal request be submitted to Health Services Command for recognition of the organization and functions of the CSD at this MEDDAC.
6. That all incoming personnel who will be assigned to managerial roles be briefed by CSD personnel on the roles and responsibilities of this division.
7. That this organizational model not be implemented until the Chief, Speciality Care and Ancillary Support Branch is relieved of his QAP duties and can devote fulltime attention to CSD support responsibilities.
8. That the junior officer currently assigned to the CSD be assigned as the Administrative Assistant to the CPS. The other two officers currently assigned would be designated as the Chief, and Assistant Chief, CSD.
9. That job descriptions be written for all department and service NCOICs to establish functional definition for these positions.

Footnotes

¹U.S. Department of the Army, Health Services Command. Clinical Support Division, APC Model #18. Health Services Command, Ft. Sam Houston, Texas October, 1976.

²The New Collegiate Dictionary. G.C. Merriam Co. (Springfield, Mass. 1976):15.

³May Arnold, L. Vaughn Blankenship, and John M. Hess, Administering Health Systems. (Chicago: Aldine Atherton, 1971):197.

⁴Theo Haimann, Supervisory Management for Health Care Institutions. (St. Louis, 1973):8.

⁵R.Alec Mackenzie, "The Management Process in 30," The Journal of Nursing Administration 9 (November 1979):31.

⁶Eva H. Erickson, "Are Nurses Needed for Administration or Management in Hospitals?" Journal of Nursing Administration (July/August, 1974):20-21.

⁷Modern Management Methods and the Organization of Health Services. The World Health Organization. (Geneva, 1974):14.

⁸Richard L. Durbin and W. Herbert Springall, Organization and Administration of Health Care. (St. Louis: The C.V. Mosby Co: 1974):63.

⁹Peter Drucker, "At the Frontier of Management, Hospital Administration in the 80's" Hospital Forum 22 (June 1979):8.

¹⁰Nancy K. Jones and Jack W. Jones, "The Head Nurse: A Managerial Definition of the Activity Role Set," Nursing Administration Quarterly 3 (Winter, 1979):56.

¹¹Fred C. Munson and Shyam S. Heda. "Service Unit Management and Nurses Satisfaction," Health Services Research 11 (Summer, 1976):141.

¹²The Honorable Vernon McKenzie in "Federal Medical Chiefs on Progress and Plans," Military Medicine 144 (September, 1979):570.

¹³Derek Meyers, "The New Disease - Administration?" The British Medical Journal (21 June, 1975):677-679.

¹⁴Charles U. Letourneau, The Hospital Administrator. (Chicago: Stanley Pub., 1969):36.

¹⁵Shyam Heda and Michael Shirk, "Human Resource Accounting System and Productivity Monitoring," Hospital and Health Services Administration 24 (Fall, 1979):36-45.

¹⁶Barbara Kehner and Michael Intriligator, "Task Delegation in Physician Office Practice," Inquiry 11 (December, 1974):298.

APPENDIX A

Ambulatory Patient Care Model #18

CLINICAL SUPPORT DIVISION

AN AID FOR INNOVATION

Prepared as a requirement for the
United States Army Health Services Command
Ambulatory Patient Care (APC) Program

APC Model #18
HSPA-A
October 1977

APC Model #18
1 Oct 77

TABLE OF CONTENTS

	<u>Page</u>
SECTION I GENERAL	1
Purpose	1
Scope	1
II DISCUSSION	1
III RECOMMENDATIONS	2
IV SUMMARY	4
ANNEX A Administrative Support of Professional Departments Organizational Relationships.	A-1
ANNEX B Proposed Clinical Support Division for a 75-125 Bed Hospital	B-1
ANNEX C Clinical Support Division, Duties and Functions Guide	C-1 thru C-4

This model supersedes APC Model #18 dated July 1974

SECTION I

GENERAL

1. Purpose. The purpose of this model is to assist the medical treatment facility (MTF) Commander in establishing an improved administrative management system with the goal of increasing physicians' time available for direct patient care.

2. Scope. This model is applicable to hospitals assigned to US Army Health Services Command (HSC). The organizational concepts proposed in this model are in consonance with HSC Reg 10-1.

3. Definitions. (Applicable only to this model)

a. Patient Care Elements (PCE). Refers to those organizational elements within a hospital normally providing direct patient care services (such as the Departments of Medicine, Surgery, Psychiatry, Primary Care, and ancillary services such as Pathology, Radiology, Pharmacy, Optometry, Podiatry, etc.).

b. Administrative Support Elements (ASE). Refers to administrative branches, sections, or individuals assigned within PCE, or centralized services that administratively support the PCE of the hospital.

SECTION II

DISCUSSION

4. Current and projected physician shortages necessitate maximum effectiveness in hospital management. Physicians and other PCE staff members can be relieved of unwanted or assumed administrative tasks only if management can provide effective administrative support personnel to accomplish these functions. Another consideration in developing an administrative management system is to insure the maximum utilization of the education and experience of assigned administrative personnel.

5. To maximize effectiveness, there should be a centralized system of management supervision to provide uniform guidance to all administrative personnel. By grouping all the ASE under a single manager, a more flexible, responsive and dedicated service is possible. Through proper management, this organizational change allows PCE personnel increased time for direct patient care.

6. An organizational structure proposed to effect this change, described in Section III, is also expected to:

a. Identify and group like functions within the organization.

APC Model #18
1 Oct 77

- b. Improve management supervision of the administrative support provided to PCE.
- c. Insure maximum use of the education and experience of assigned administrative personnel.
- d. Enhance the job satisfaction and career development of the junior hospital manager.
- e. Delineate a progressive career pattern leading to SSI 67A.
- f. Ultimately produce more clinically oriented senior hospital managers.

SECTION III

RECOMMENDATIONS

7. The following recommendations to establish a Clinical Support Division (CSD) represent a composite of tested, effective organizational concepts capable of providing improved service to the clinical staff using existing resources. Annexes A and B graphically depict a CSD that will support a 75-125 bed hospital.
- a. The CSD should be staffed and organized based on the functions it must accomplish (See Annex C). If adequate staffing is not currently available, document and justify the additional personnel requirements.
 - b. This organizational model can be adapted readily to a larger facility where sufficient administrative assistants already exist. The model for a 75-125 bed facility requires two administrative officers to make the organization effective. The number of TDA administrative support personnel shown in Annex B was taken from actual manpower allocations to a 90-bed hospital.
 - c. It should be noted that a centralized stenographic service is provided in the Administrative Support Section, Ambulatory Care Support Branch of this model. This function may or may not be provided subject to the desires of the MTF Commander and the availability of resources.
 - d. The attached duties and responsibilities summary (Annex C) may be used as a guide for developing on-site job descriptions. An additional guide for an Administrative Officer is provided for larger MTF able to justify more than one officer space. Smaller MTF should consolidate the two guides.
 - e. The C, CSD should be rated by the Executive Officer (XO) or Chief, Professional Services (CPS) (depending on who is given direct supervisory responsibility).

8. Larger MTF may transfer to the Inpatient and Ancillary (IA) Service Branch spaces such as: (1) administrative assistants, (2) receptionists, (3) medical library personnel, (4) clerk-typists or (5) others in the office of the CPS or in departments/services whose duties are administrative in nature. "Duty station" should remain for the most part the same area as before, but the individuals will now be supervised by the IA Branch Assistant Administrator.

9. There should be no administrative gaps in the hospital system, e.g.; clinic, service, or ward clerk positions that basically have no tie-in with the hospital administrative system. An effective IA Branch can establish a supervisory chain which provides central guidance, support, flexibility, and coverage during periods of leave and other absences.

10. Current experience indicates the following factors should be considered:

a. A centralized physical office arrangement for the CSD is most effective for small MEDDAC. The larger the MEDCEN/MEDDAC the more decentralized the offices should be.

b. The total management of the CSD has proven most effective under the supervision of the XO. The term Associate Administrator should be used for the C, CSD only when under the XO's supervision.

c. The continuing trend is to place all appropriate services (both inpatient and outpatient) under a given specialty chief, e.g., Chief, Department of Medicine. The outpatient services under the Ambulatory Care Support Branch will, therefore, be reduced (Ref HSC Reg 10-1). In larger MEDDAC a very effective alternative to that described in Annex B is the establishment of a:

(1) Specialty Care Support Branch supervising the Departments of Medicine, Surgery, Psychiatry, Neurology and associated areas. This branch could be divided for very large MEDDAC or MEDCEN.

(2) Primary Medical Services Support Branch supervising AMIC, Emergency Treatment Service, Physical Examination Service and Troop Medical Clinics.

(3) Ancillary Services Support Branch supervising Medical Library, Central Appointment Service, Patient Representative Office and points of contact for Pharmacy Service, Pathology and Radiology. The latter two have proven to be very productive management areas because of high dollar expenditure.

d. The proposed duties and responsibilities listed in Annex C can be redistributed to fit the preceding organizational concepts.

e. Identify and clarify local responsibilities with regard to CSD and Department of Nursing areas of operation.

APC Model #18
1 Oct 77

11. The successful implementation of the CSD concept at any MTF is a function of many variables. Among the most important are:

- a. The attitudes and philosophies of the CO, XO and CPS pertaining to the structure and management of the hospital organization.
- b. The formulation of a mission statement which clearly delineates specific areas of responsibility and commensurate authority. (Establish a clear line of demarcation).
- c. The avoidance of any actions that might appear to the professional and administrative staffs to represent usurpation of their respective areas of responsibility.
- d. The availability of adequate well-situated office space for day-to-day work, counseling, patient encounters and meetings.

SECTION IV

SUMMARY

12. Proposals presented in this model may be adopted in total, modified or implemented in part, but regardless of the structure used, it must be designed to be more responsive managerially to the department/service chief in particular, and the physician in general. This model has been expanded beyond the normal APC area to eliminate any competition that may exist between inpatient and outpatient administrative services, and to insure a coordinated effort toward unity of purpose.

APC Model #18
1 Oct 77

The proponent agency of this model is the Deputy Chief of Staff, Professional Activities. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) to CDR, HSC, ATTN: HSPA-A, Fort Sam Houston, TX 78234.

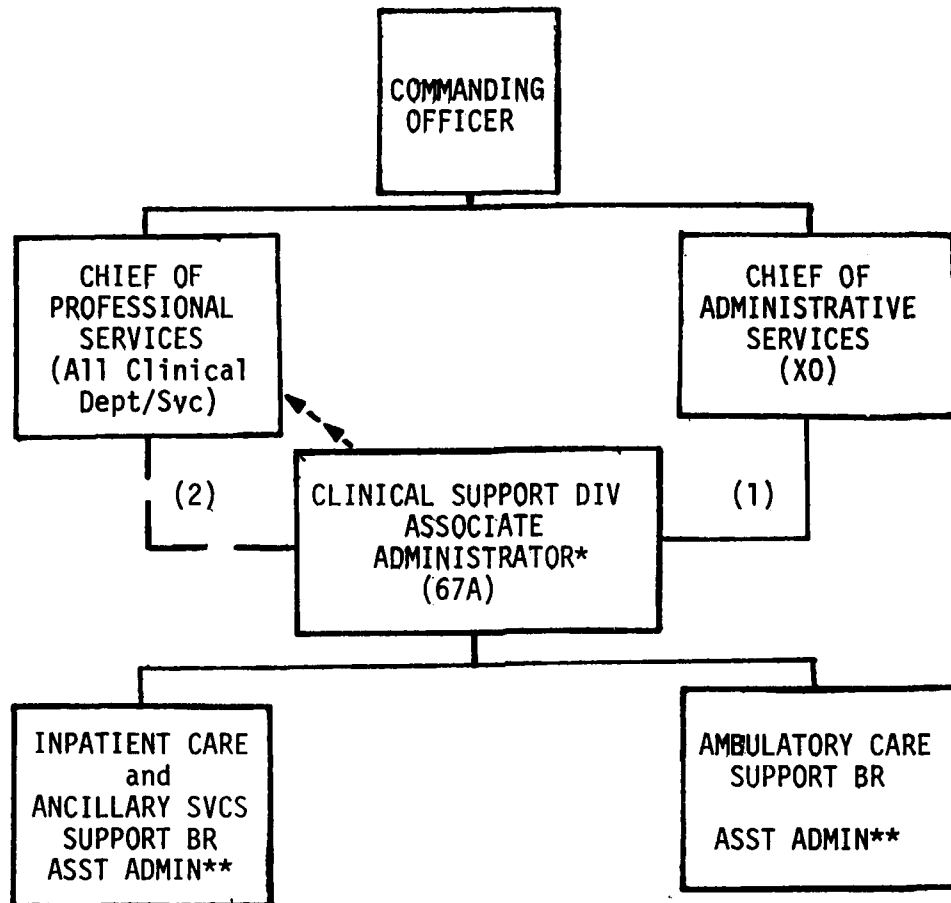
FOR THE COMMANDER:



PHILIP A. DEFFER, M.D.
Brigadier General, MC
Chief of Staff

THEODORA H. NAGEL
Colonel, AGC
Adjutant General

ANNEX A

Administrative Support of Professional Departments
Organizational Relationships

____ Optional chain of supervision (Hospital Commander option).

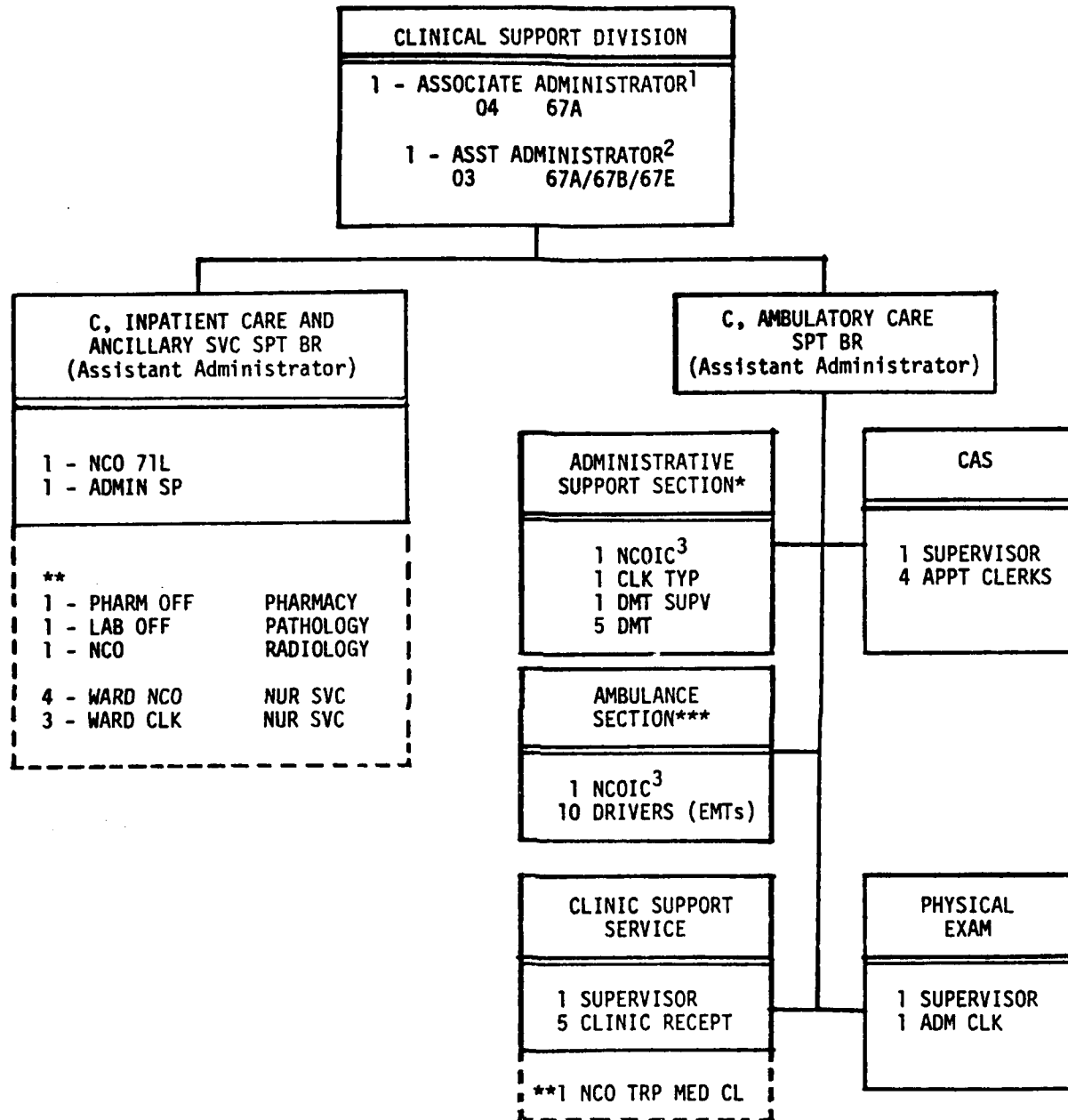
- (1) Chain of supervision should be given to the X0 to retain administrative actions within the current administrative management system and reduce non-medical supervisory tasks of the CPS,
- (2) May be given to the CPS to make the organization directly responsible to the clinical staff.

— — Administrative/technical support provided all clinical departments and services.

*Has an additional duty as chief of one of the branches.

**May be SSI 67A.

**Proposed Clinical Support Division
for a 75-125 Bed Hospital**



¹Additional duty as Chief, Inpatient Care and Ancillary Svc Spt Branch.

²Additional duty as Chief, Ambulatory Care Support Branch.

³Additional duty as NCOIC of the Ambulance Section.

*Includes a typing pool to provide centralized typing support to ambulatory care activities

**Are points of contact for administrative coordination. Service to speciality continues as before.

***For "Ambulances" only, not patient transport vehicles. OPCON under C, EMS.

ANNEX C

CLINICAL SUPPORT DIVISION

DUTIES AND FUNCTIONS GUIDE

1. Chief, Clinical Support Division (Associate Administrator). The Associate Administrator should be a Medical Service Corps (MSC) officer who will be responsible to the Executive Officer (XO) or Chief of Professional Services (CPS) for the planning, organizing, directing, staffing, budgeting, and evaluating the administration of clinical service operations. He should insure that optimal efficiency, effectiveness and economy of operations are maintained at all times. Major tasks include:

- a. Advising and consulting with the XO and CPS on matters relative to specific areas of responsibility.
- b. Providing managerial support to all professional activities.
- c. Directing and coordinating operations of assigned management activities; discussing, reviewing, and evaluating operational matters, policies, and procedures with Assistant Administrators.
- d. Interpreting and communicating objectives, policies and directives to Assistant Administrators of Division.
- e. Coordinating matters pertaining to the Joint Commission on Accreditation of Hospitals (JCAH).

2. Assistant Administrator for Inpatient Care and Ancillary Services. The Assistant Administrator for Inpatient Care and Ancillary Services should be an MSC officer who may be responsible for the following functions:

- a. Managing administrative support for inpatient activities of the hospital.
- b. Developing the budget for inpatient activities in coordination with clinical chiefs and exercising some degree of supervisory control over the expenditures generated for inpatient care.
- c. Assisting the CPS in planning and coordinating medical continuing education programs.
- d. Developing appropriate mobilization and emergency operating procedures in conjunction with the overall hospital plan.

ANNEX C to APC Model #18

e. Monitoring the timely completion of inpatient medical records, medical board actions, and TDRL evaluation, (assisting the Patient Administration Division (PAD)).

f. Assisting the CPS in establishing effective controls to insure timely disposition of hospitalized patients.

g. Developing an effective interpersonal relations program to further promote the concept of "concerned care."

h. Coordinating logistical support and the practice of supply economy for inpatient activities.

i. Providing stenographic and typing support to the hospital inpatient activities (other than PAD responsibilities).

j. Operating the hospital information desk.

k. Maintaining liaison with ambulatory care services to insure proper coordination of follow-up care for inpatients.

l. Supervising procedures and coordination of patient transfers to and from the hospital (assisting the PAD).

m. Maintaining liaison with local civilian hospitals (as appropriate).

n. Supervising personnel not engaged in the direct provision of patient care.

o. Supervising Manpower Management Program for inpatient care activities.

3. Administrative Officer - Inpatient Care and Ancillary Service.

Administrative Officer(s) assigned to Inpatient Care and Ancillary Services should be MSC officer (s) who may be responsible for the following functions:

a. Conducting necessary orientations for newly assigned personnel.

b. Arranging the conduct of inservice education.

c. Providing administrative support for the clinical departments' budgetary processes.

d. Maintaining ward occupancy data and effecting necessary coordination with PAD for the processing of incoming and outgoing patients.

- e. Supervising the ordering of supplies, publications and materials as appropriate.
- f. Establishing procedures in support of overall hospital disaster plans.
- g. Providing necessary assistance to the professional staff in the timely completion of inpatient medical records.
- h. Monitoring control procedures for narcotics and other sensitive materials.
- i. Compiling statistical data for the preparation of required reports.
- j. Arranging for necessary support to next of kin and other personnel requiring specialized assistance.
- k. Collecting and consolidating data in support of the manpower management program.
- l. Managing property and maintaining property accountability.

4. Assistant Administrator for Ambulatory Services. The Assistant Administrator for Ambulatory Services should be a MSC officer who may be responsible for the following functions:

- a. Managing clinics within and subordinate to the hospital. In this connection, he should also establish controls for expenditures and coordinate the submission of budgetary requirements. (Responsibility for professional management of patients is vested in the CPS).
- b. Utilizing personnel, facilities, and supplies in support of optimum patient care through coordination with other departments and services.
- c. Operating a Central Appointment Service for hospital clinics.
- d. Monitoring educational programs applicable to clinic support personnel in cooperation with other departments and services.
- e. Operating an interpersonal relations program in the care and management of ambulatory patients. In this connection, he is responsible for the publication and distribution of appropriate guidance/information to clinic patients.
- f. Monitoring the timely preparation and administration of out-patient medical records.
- g. Preparing and submitting reports and maintaining records as required.

ANNEX C to APC Model #18

- h. Reviewing clinic work methods and operational procedures.
 - i. Providing logistical and administrative support to specialty clinics.
 - j. Supervising the Manpower Management Program for ambulatory care activities.
5. Administrative Officer - Ambulatory Care. The Administrative Officer(s) for hospital-based and satellite clinics should be a MSC officer who may be responsible for the following functions:
- a. Exercising administrative control over the operation of clinics providing sick call, emergency medical treatment, occupational health services, and/or preventive medicine services. (Responsibility for professional management of patients is vested in the CPS).
 - b. Insuring timeliness and administrative completeness of outpatient medical records.
 - c. Preparing and submitting reports, and maintaining records as required.
 - d. Determining if patients seeking medical care or services are eligible beneficiaries.
 - e. Managing the physical examination facility.
 - f. Insuring proper scheduling of sick call, physical examinations, physical profiling, immunizations and medical processing (coordinating such activities with commander of supported units).
 - g. Providing emergency ambulance service and coordinating administrative movement of patients, to include the evacuation and transfer of patients.
 - h. Maintaining and collecting data in support of the Manpower Management Program.

AD-A195 874

A STUDY TO DETERMINE THE BEST ORGANIZATION FOR A
CLINICAL SUPPORT DIVISIO. (U) ACADEMY OF HEALTH
SCIENCES (ARMY) FORT SAN HOUSTON TX HEALTH C.

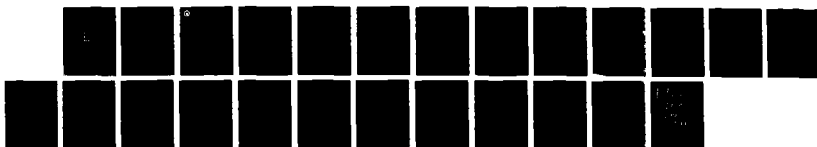
2/2

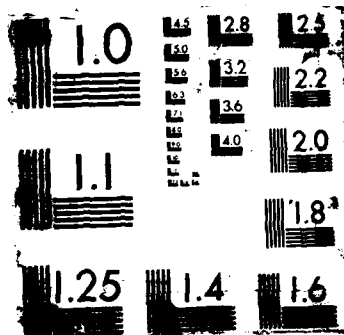
UNCLASSIFIED

T VAN HOOK 01 AUG 81 HCA-8-88

F/G 6/5

NL





APPENDIX B

Command Letter Supporting APC Models



DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY HEALTH SERVICES COMMAND
FORT SAM HOUSTON, TEXAS 78234

HSPA-A

JUL 15 1980

SUBJECT: Ambulatory Patient Care (APC) Program Document

Commanders
HSC MEDCEN/MEDDAC

1. The Ambulatory Patient Care (APC) Program continues to be one of the high priority missions of the US Army Health Services Command. Although significant qualitative improvements have been made in our ambulatory care delivery, the personnel and fiscal resource limitations within which we now operate present a continuous challenge. To meet this challenge, we must seek methods through which we can improve the efficiency of health care operations without sacrificing the quality of medical care. To this end, we must each give our enthusiastic support and rededicate our efforts to insure its continued success.

2. The FY 78 APC Program and supporting models have been reviewed, updated and revised to reflect changes dictated by experience and existing resources. I would like to emphasize that the requirement for a viable APC Program within Health Services Command has not diminished since its inception in 1974. I personally endorse the program, encourage its dissemination within the MEDCEN/MEDDAC organizational structure, and solicit support for it throughout the command.

RAYMOND H. BISHOP, JR., M.D.
Major General, MC
Commanding

APPENDIX C

Current Organization of the Clinical Support Division of USA MEDDACC Ft. Ord.

Section 14

Clinical Support Division

1. GENERAL.

a. The mission of the Clinical Support Division (CSD) is to provide centralized administrative management support to all professional elements of the hospital.

b. The division will be under the direct supervision of the Chief, Professional Services.

2. ORGANIZATION.

a. Office of the Chief. Functions include:

(1) Development of the operating program for the division.

(2) Provision of managerial support to professional elements including.

(a) Professional meetings and conferences.

(b) Medical Library.

(c) Budget planning, coordination, preparation, and supervision.

(d) Logistical matters.

(3) Coordination of activities pertaining to hospital accreditation by the JCAH.

(4) Development and operation of appropriate training programs.

(5) Review and analysis of administrative work methods and operational procedures within the division and other professional elements as directed.

(6) Incumbent is also designated associate administrator for Professional Services.

(7) Coordinates and provides administrative support to the Quality Assurance Program.

b. Specialty Care and Ancillary Support Branch. Functions include:

- (1) Management of administrative support activities for designated professional inpatient and ancillary organizational elements.
- (2) Coordination of inservice education programs excluding nursing.
- (3) Liaison and assistance to the Patient Administration Division concerning:
 - (a) Timely completion of inpatient medical records.
 - (b) Timely disposition of hospitalized patients.
 - (c) Patient transfer procedures.
 - (d) Timely coordination in the processing of medical boards.
- (4) Provision of administrative stenographic and typing support services as required. This function does not include support for PAD responsibilities or the central word processing activity of the hospital.
- (5) Development of an effective interpersonal relations program regarding concerned patient care.

c. Primary Care Support Branch. Operational functions include:

- (1) Management of administrative support activities for all clinics under the jurisdiction of the Chief, Department of Primary Care and Community Medicine, and Department of Family Practice.
- (2) Provision of administrative and management support to clinics operated by other hospital departments and services as directed.
- (3) Coordination for the timely preparation, completeness and content of outpatient medical records.
- (4) Publication and distribution of appropriate information of interest to clinic patients.
- (5) Coordination with the Patient Administration Division to assure timely preparation and accuracy of outpatient medical statistical and workload data submitted to PAD.

d. Patient Assistance Officer. Functions include:

- (1) Provide liaison between the various elements of the hospital and beneficiaries.
- (2) Assist patients by resolving real or perceived problems associated with accessibility to the health care delivery system.

22 JAN 1981

MR 10-1

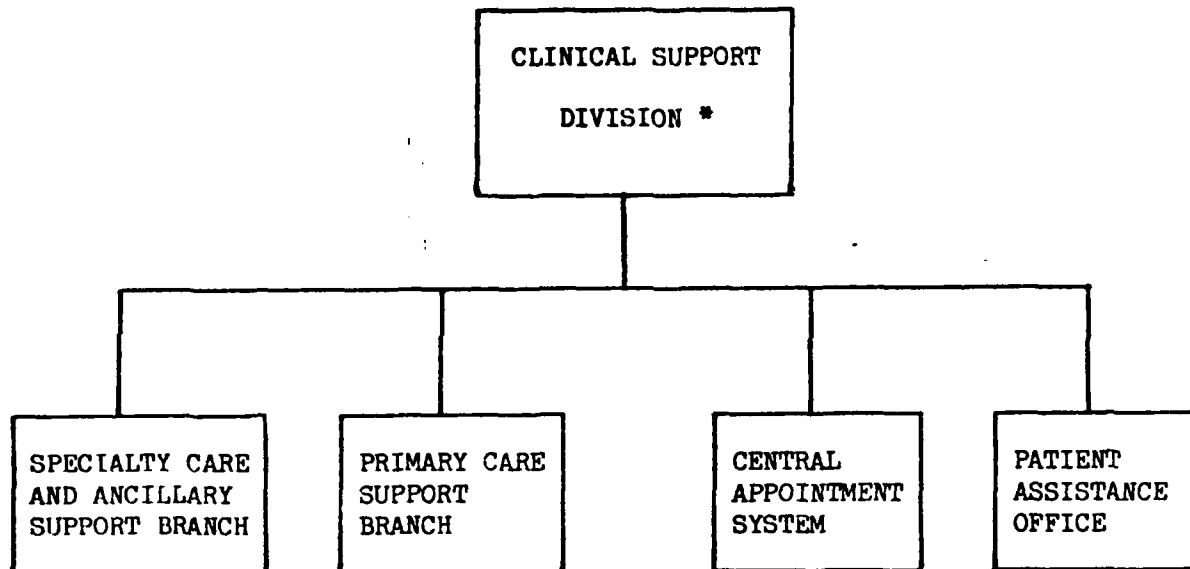
(3) Conduct investigations/surveys and recommend procedures for improving the delivery of health care.

(4) Provide administrative assistance to the Chief, Clinical Support Division.

e. Central Appointment System: Operational functions include:

(1) Staff and operate the Hospital Central Appointment System.

(2) Maintain and submit, as required, statistical reports and workload data.



* Incumbent also Associate Administrator for Professional Services.

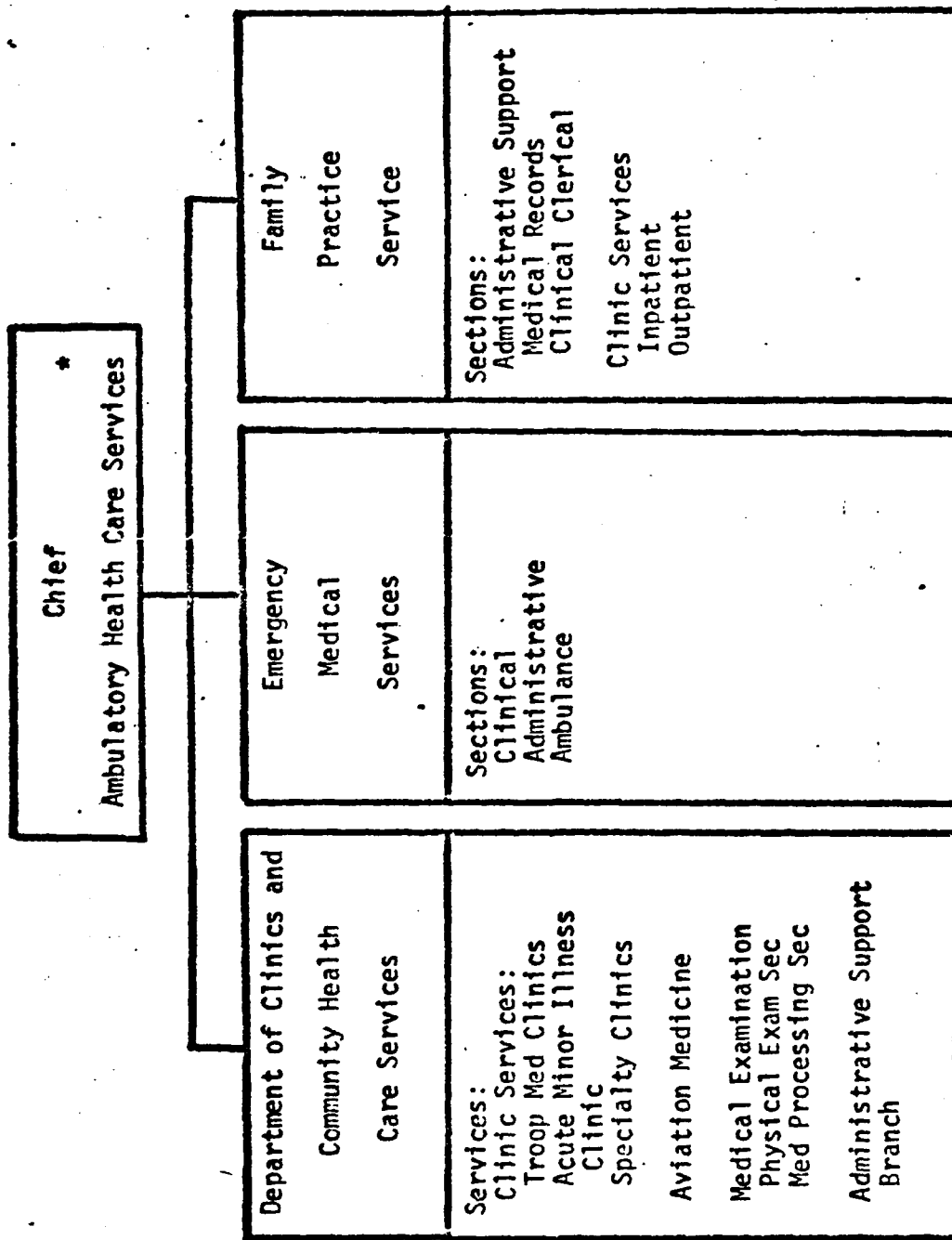
ORGANIZATIONAL CHART

Figure 17

3-48

APPENDIX D

Decentralized Arrangement of Administrative Support Assets
Prior to 1973 at the USA MEDDAC Fort Ord, California



* Indicates Approved Deviation From Organizational Pattern Published in HSC Reg 40-4.

APPENDIX E

Suggested Duties for the Administrative Assistant to the CPS

Suggested Tasks to be Performed by the Administrative Assistant to the CPS

1. Compile medical credentials from physicians for presentation to the Credentialling Committee.
2. Coordinate and complete intra and inter-office correspondence, reports, and directives as directed by the CPS.
3. Maintain duty rosters and field training assignments as directed.
4. Prepare, coordinate and monitor all awards, civilian personnel actions, committee support, and Continuing Medical Education Programs as directed.
5. Control and supervise the flow of administrative actions for the CPS.
6. Provide administrative support to the QAP coordinator.
7. Provide uniform guidance to the Prof. Svcs. NCOIC to be passed to the department/service NCOICs. Establish policies and programs to insure maximum uniformity in the supervision of the administrative assets within the professional organization.
8. Assist the CPS in planning and coordinating medical continuing education.
9. Perform the duties required at the point of contact for consultant visits.
10. Perform other duties as directed by the CPS.

APPENDIX F

Suggested Duties for the Chief, and Assistant Chief, CSD

Suggested Functions for the Chief, and/or Assistant Chief, CSD

The following is a listing of suggested functions for the Chief and/or Assistant Chief, CSD. The Chief, CSD would determine how these functions would be assigned within the CSD. These functions would be performed for all departments and services within the "professional" organization to include the Department of Nursing and the Community Mental Health Activity (CMHA).

1. Develop and supervise the MEDCASE and capital expense programs for all professional services, elements, and CMHA. CSD managers will:

a. Contact each department/service NCOIC on a monthly basis to determine the need for new or replacement items.

b. Assist these NCOICs in preparing requests for such items and will review all requests prior to submission to the MEDCASE manager.

c. Attend the working PBAC as non-voting members.

d. Maintain liason with the MEDCASE manager and the Logisitics Division to determine the status of equipment procurements.

e. Inform the NCOICs and department/service chiefs of the status of items on the prioritized equipment list.

2. Develop and supervise budget planning, coordination, and preperation. CSD managers will:

a. Contact each NCOIC on a monthly basis to determine the status of current expenditures.

b. Assist the NCOIC in analyzing reasons for over or under expenditure.

c. Assit the NCOIC in budget preparation. Review all budgets prior to submission to the Comptroller.

d. Maintain liaison with the Comptroller on budget issues.

3. Review and analyze internal work methods and resource utilization.

a. On a monthly basis CSD managers will compile workload data from the

Comptroller and statistics from the Central Appointment System.

b. CSD personnel will maintain graphic displays of the workload of each area for the month as well as Central Appointment System data on appointments made, appointments cancelled, and other data maintained by Central Appointments.

c. Comparisons of workload with resources available, appointments made, patients treated etc., will be made. Analysis of deviations in trends will be made and, if significant deviations exist, an investigation of causes will be conducted with the department/service chief.

d. Findings and recommendations will be presented to the department/service chief and the CPS.

4. Provide managerial assistance to all professional staff elements.

a. Assist department/service personnel in problem identification, problem solving, policy and procedure development, systems analysis and design, and related issues as requested or assigned.

b. Conduct formal studies, projects, missions as assigned by the Commander, CPS, Executive/Quality Assurance Committee, or the Chief, CSD.

5. Assist in the implementation of the Ambulatory Patient Care Program.

a. Attend APC Committee meetings to provide input and suggest areas for action or improvement.

b. Assume projects related to APC Program implementation as directed by the CPS or Chief, CSD.

6. Coordinate activities of all departments/services/CMHA pertaining to hospital accreditation by the JCAH.

7. In coordination with the Patient Assistance Office and the MEDDAC IG, advise the CPS on matters pertaining to the equality, quality, quantity, and problems pertaining to patient care services and delivery systems.

8. Provide administrative management support to all departments and services under the CPS.

a. Determine and prioritize needs for such support and assign "float" clerk stenos to those areas with a demonstrated need for support.

b. Coordinate with the Director of Volunteers to facilitate the assignment of volunteer administrative procedure assets to areas within the "profesional" organization.

SELECTED BIBLIOGRAPHY

Government Documents

- U.S. Department of the Army. Staffing Guide for U.S. Army Medical Department Activities. DA Pamphlet 570-557, Headquarters, Dept. of the Army, Washington D.C: June 1974.
- U.S. Department of the Army. Medical and Quality Assurance Administration. AR 40-6 Headquarters, Department of the Army, Washington, D.C: 15 June, 1980.
- U.S. Department of the Army. Composition, Mission, and Functions of the Army Medical Department. AR 40-1, Headquarters, Department of the Army, Washington, D.C: 1 May, 1979.
- U.S. Department of the Army, Health Services Command. Ambulatory Patient Care Program, Administrative Management. Chapter 2, Section A. U.S. Army Health Services Command, Fort Sam Houston, Texas: 1 July, 1978.
- U.S. Department of the Army, Health Services Command. Ambulatory Patient Care. AR 40-5. Headquarters, U.S. Army Health Services Command, Fort Sam Houston, Texas: 1 October, 1977.
- U.S. Department of the Army, Health Services Command. Clinical Support Division. Ambulatory Patient Care Model #18. U.S. Army Health Services Command, Fort Sam Houston, Texas: October, 1977.
- U.S. Department of the Army, U.S. Army Health Services Command. Organization and Functions Manual. AR 10-1. U.S. Army Health Services Command, Fort Sam Houston, Texas: 1 November, 1978.
- U.S. Department of the Army, Medical Department Activity, Fort Ord. Quality Assurance Program. MR 40-2. Fort Ord, California: 3 October, 1980.
- U.S. Department of the Army, Medical Department Activity, Fort Ord. Uniform Chart of Accounts. MR 37-1. Fort Ord, California. 12 January, 1981.

Unpublished Manuscripts

- Frelen, A.J. and Horak, Bernard J. "Use of an In-House Management Consultant in the Role-Development of the Head Nurse". Fort Hood, Texas: 1980.
- Konarik, Ronald B. and Reed, Wayne. "Work Environment Improvement Teams: A Military Approach to Quality Circles." Fort Ord, California: 1981.
- Major Peter D. Tremblay, Captain Mary Lambert, Colonel Jose, R. Ossoria. "A Systems Analysis of the Clinical Support Concept". U.S Army-Baylor Program in Health Care Administration, Academy of Health Sciences, Fort Sam Houston Texas: 1980.

Books

- Arnold, Mary, Blankenship, L. Vaughn, and Hess, John M. Administering Health Services. Chicago: Aldine Atherton. 1971.
- Bennett, Addison C. Improving Management Performance in Health Care Institutions. Chicago: American Hospital Association. 1978.
- Berman, Howard J. and Weeks, Lewis E. The Financial Management of Hospitals. Ann Arbor, Michican: Health Administration Press. 1971.
- Berne, Eric. The Structure and Dynamics of Organizations and Groups. New York: Grove Press Inc. 1963.
- Donabedian, Avedis. Aspects of Medical Care Administration. Cambridge, Massachusetts: Harvard University Press. 1973.
- Donnelly, James H., Gibson, James L., and Ivancevich, John M. Fundamentals of Management. Dallas, Texas: Business Pub. Inc. 1975.
- Durbin, Richard L. and Springall, W. Herbert. Organization and Administration of Health Care. St. Louis: The C.V. Mosby Co. 1974.
- Drucker, Peter F. Management. New York: Harper and Row Pub. 1974.
- Galbreth, Jay R. Organizational Design. Reading, Massachusetts: Wesley Pub. Co. 1977.
- Goldstein, Harold M. and Horowitz, Morris. Health Personnel. Germantown, Maryland: Aspen Systems Corporation. 1977.
- Gumbiner, Robert. HMO: Putting It All Together. St. Louis: The C.V. Mosby Co. 1975.
- Haiman Theo. Supervisory Management for Health Care Institutions. St. Louis: The Catholic Hospital Association. 1973.
- Hicks, Herbert C. Management, Organization, and Human Resources. New York: McGraw-Hill Book Co. 1972.
- Ivancevich, John M., Szilagyi, Andrew D., Jr., Wallace, Marc J. Jr. Organizational Behavior and Performance. Santa Monica: Goodyear Pub. Co., Inc. 1977.
- Johnson, Richard A., Kast, Fremont E., and Rosenzweig, James E. The Theory and Management of Systems. New York: McGraw-Hill Book Co. 1965.
- Koontz, Harold and O'Donnell, Cyril. Essentials of Management. New York: McGraw Hill Book Co. 1978.
- Kover, Anthony and Neuhauser, Duncan, Editors. Health Services Management. Ann Arbor, Michican: Health Administration. 1978.

- Leavitt, Harold J., Dill, William R., and Eyring, Henry B. The Organizational World. New York: Harcourt-Brace-Jovanich, Inc. 1973.
- Letourneau, Charles U. The Hospital Administrator. Chicago: Stanley Publications. 1969.
- Levey, Samuel and Loomba, N. Paul. Health Care Administration. Philadelphia: J.B. Lippincott Co. 1973.
- Levey, Samuel and McCarthy, Thomas. Health Management for Tomorrow. Philadelphia: J.B. Lippincott Co. 1980.
- Longest, Beaufort B. Jr. "Relationship Between Coordination, Efficiency, and Quality of Care in General Hospitals" in Health Services Management. Editors, Anthony Kover and Duncan Newhauser. Ann Arbor, Michigan: Health Administration Press. 1978.
- MacEachern, Malcolm T. Hospital Organization and Management. Chicago: Physicians Record Co. 1957.
- Magnusen, Karl O. Organizational Design, Development, and Behavior. Glenview, Ill: Scott, Foresmon, and Co. 1977.
- Minor, John B. Management Theory. New York: The McMillan Co. 1971.
- Pauly, Mark V. Doctor's and their Workshops: Economic Models of Physician Behavior. Chicago: University of Chicago Press. 1980.
- Rakich, Jonathon, and Darr, Kurt. Hospital Organization and Management. New York: SP Medical and Scientific Books. 1978
- Reinhart, Uve. E. Physicians Productivity and the Demand for Health Manpower. Cambridge, Massachusetts: Ballenger Pub. Co. 1975.
- Robbins, Stephen P. The Administrative Process. Englewood Cliffs, N.J.: Prentice Hall Inc. 1976.
- Sutherland, John W. Administrative Decision Making. New York: Van Nostrand-Reinhold Co. 1977.
- Townsend, Robert. Up the Organization. New York: Alfred A. Knopf. 1970.
- Uyterhoeven, Hugo E. "General Managers in the Middle" in Managerial Behavior and Organizational Demands. edited by Golembiewski, Robert T., Gibson, Frank, and Miller, Gerald. Itasca, Ill: F.E. Peacock Pub. Inc. 1978.
- Warner, D. Michael and Halloway, Don C. Decision Making and Control for Health Administration. Ann Arbor, Mich: Health Administration Press. 1978.
- White, Bernard J., Stamm, John H., and Foster, Lawrence W. Cases in Organization. Dallas: Business Pub. Inc. 1976.
- _____. Job Description and Organizational Analysis for Hospitals and Related Health Services. Washington: United States Department of Labor. 1971.

. Modern Management Methods and the Organization of Health Services.
Geneva: The World Health Organization. 1974.

Periodicals

- Adkins, Richard D. "Responsibility and Authority Must Match in Nursing Management." Hospitals 13 (1 February 1979): 69-71.
- Anderson, Theodore R. and Warkov, Seymour. "Organizational Size and Functional Complexity: A Study of Administration in Hospitals." American Sociological Review 26 (1961): 23-28.
- Baldwin, L. Eugene. "An Empirical Study: The Effect of Organizational Differentiation and Integration on Hospital Performance." Hospital Administration 17 (Fall 1972): 52-71.
- Bauerschmidt, Alan D. "The Hospital as a Prototype Organization." Hospital Administration 15 (Spring 1970): 6-14.
- Braden, Frank M. "Unit Managers Serve as Liaison Between Administration and Words." Hospitals 50 (1 October 1976): 91-94.
- Bridgid, M. "New Titles Help Morale and Administration." Modern Hospitals 111 (July 1968): 144-146.
- Brown, Bernard L. and Bowling, John S. "Administrator, Assistant Relate in Cooperation and in Challenge." Hospitals 50 (1 August 1976): 75-77.
- Cascino, Anthony E. "How One Company Adapted Matrix Management in a Crisis." Management Review 68 (November 1979): 57-61.
- Cohen, Meyer W. "Arguments For and Against MBO." Hospital and Health Services Administration 25 (Special 1980): 48-55.
- Conner, Hatcil L. "A New Title on the Administrative Team." Hospitals 107 (September 1966): 97-101.
- Davis, John A. and Bord, Marc A. "Reorganization of Ambulatory Services in a Community Hospital." The Journal of Ambulatory Care Management 2 (February 1979): 21-28.
- Davis, Robert N. "Five Steps to Program Success." Hospitals 47 (1 July 1973): 38-42.
- Davis, Robert N. "Productivity Improvement Can Cut Costs." Hospitals 49 (16 February 1979): 49-52.
- Duncan, David J. "Geisinger Hospital/Clinic Contains Costs in Secretarial Services, Saves \$235,606 Per Year." Hospital Topics 57 (November-December 1979): 18-21.

- DePaolo, Vince. "Proprietary Systems Have More Specialists on Staff." Modern Healthcare (April 1979): 47-51.
- Dittrich, John E., Long, James R., and White, Sam E., "Nurses Management Problems and Their Training Implications." Personnel Journal (May 1979): 314-317.
- Dowling, Alan F., Jr., "Do Hospital Staff Interfere With Computer System Implementation?" HCM Review (Fall 1980): 23-32.
- Duncan, Robert. "What is the Right Organization Structure?" Organizational Dynamics (Winter 1979): 59-80.
- Elnicki, Richard A. "Hospital Productivity, Service, Intensity, and Cost." Health Services Research 9 (Winter 1978): 270-293.
- Erickson, Eva. "Are Nurses Needed for Administration or Management in Hospitals?" Journal of Nursing Administration 4 (July-August 1974): 20-21.
- Ewell, Charles M. Jr., "Organizing Along Corporate Lines." Hospitals 46 (1 July 1972): 58-62.
- Farlee, Coralie. "The Computer as a Focus of Organizational Change in Hospitals." Journal of Nursing Administration 13 (February 1978): 20-26.
- Farris, Bain J. "Physician/Administrator Partnership: An Answer to Ambulatory Care Programming." The Journal of Ambulatory Care Management 1 (November 1978): 47-57.
- Friedman, Emily. "Breaking the Bottleneck: The Administrator as Delegator." Hospitals 52 (February 1, 1978): 71-78.
- Gaynor, Alan, and Berry, Rosalie. "Observations of a Staff Nurse: On Organizational Analysis." Journal of Nursing Administration 3 (May-June 1973): 43-49.
- Geogopolis, Basil, and Mann, Floyd. "The Hospital as an Organization." Hospital Administration 7 (Fall 1962): 50-64.
- Grossman, Lee. "A Manager's Approach to the Paperwork Explosion." Management Review 67 (September 1978): 57-61.
- Gupta, Ishwar, Farrell, John T., and Gugnani, Haryash P. "How the Revised Unit Management Program at Cook County Hospital Eliminated 87 Jobs and saved \$40,000." Hospital Topics 54 (September-October 1976): 35-42.
- Hanoly, Charles. "Through the Organizational Looking Glass." Harvard Business Review 58 (January-February 1980): 115-121.
- Harris, Jeffrey E. "The Internal Organization of Hospitals: Some Economic Implications." Bell Journal of Economics 8 (Autumn 1977): 467-481.

- Howe, G. Edwin. "Decentralization Aids Coordination of Patient Care Services." Hospitals 43 (1 March 1969): 53-55.
- Hudson, James I. and Infield, Marcel D. "Ambulatory Care Reorganization in Teaching Hospitals." The Journal of Ambulatory Care Management (February 1980): 31-49.
- Hurka, Slavek. "The Impact of Managerial Orientation on Need Satisfaction." Hospital Topics 57 (September-October 1979): 18-20, 44-45.
- Ivancevich, John and Donnelly, James H. Jr. "A Study of Role Clarity and Need for Clarity for Three Occupational Groups." Academy of Management Journal 17 (March 1974): 28-36.
- Ivancevich, John, Watson, Michael J., McMahon, Timothy. "Understanding Professional Job Attitudes." Hospital and Health Services Administration 25 (Winter 1980): 53-68.
- Jones, Nancy K. and Jones, Jack W. "The Head Nurse: A Managerial Definition of the Activity Role Setp." Nursing Administration Quarterly 3 (Winter 1979): 45-56.
- Kast, Fremont E. and Rosenzweig, James e. "Hospital Administration and System Concepts." Hospital Administration 11 (Fall 1966): 17-33.
- Kehner, Barbara and Intriligator, Michael D. "Task Delegation in Physician Office Practice." Inquiry 11 (December 1974): 292-300.
- Knapp, Sally E. "The Assistant Administrator: His Job and Future." Hospitals 39 (16 February, 1965): 65-67.
- LeBell, Don. "Managing Professionals: The Quiet Conflict." Personnel Journal 59 (July 1980): 566-572.
- Longest, Beaufort B. Jr. "Productivity in the Provision of Hospital Services: A Challenge to the Management Community." Academy of Management Review 2 (July 1977): 475-483.
- Love, Judith, Love, Lester B., and Leinhardt, Samuel. "Medical Manpower Models: Need, Demand, and Supply." Inquiry 12 (March 1975): 97-123.
- McCashey, Michael B. "An Introduction to Organizational Design." California Management Review 17 (Winter 1974): 13-20.
- Mackenzie, R. Alec. "The Management Process in 3D." The Journal of Nursing Administration 9 (November, 1979): 30-34.
- McKenzie, Vernon. "Federal Medical Chiefs on Progress and Plans." Military Medicine 144 (September 1979): 569-586.
- Meyer, John W. and Rowon, Brian. "Formal Structure of Organizations as Myth and Ceremony." American Journal of Sociology 83 (September 1977): 340-363.

- Miles, Rufus E. "Miles's Six Other Maxims of Management." Organizational Dynamics (Summer 1979): 27-40.
- Miller, Patricia W. "Open Minds to Old Ideas: A New Look at Reorganization." Nursing Administration Quarterly 3 (Winter 1979): 77-83.
- Moore, Edward. "The Effect of Formalization on Organizational Adoption Behavior." Organization and Administrative Sciences 8 (Winter 1977/1978): 160/
- Moore, Terrance and Lorimer, Bernard. "The Matrix Organization in Business and Health Care Institutions: A Comparison." Hospital and Health Services Administration (Fall 1976): 26-34.
- Moore, Terrence F. and Simendinger, Earl. "The Matrix Organization: It's Significance to Nursing." Nursing Administration Quarterly 3 (Winter 1979): 25-30.
- Moore, Terrence and Wood, Duane. "Power and the Hospital Executive." Hospital and Health Services Administration 24 (Spring 1979): 30-41.
- Munson, Fred C. and Heda, Shyom S. "Service Unit Management and Nurses Satisfaction." Health Services Research 11 (Summer 1976): 128-142.
- Nelson, Glenn M. and Schaefer, Marguerite. "An Integrated Approach to Developing Administrations and Organizations." The Journal of Nursing Administration 10 (February 1980): 37-40.
- Neuhauser, Duncan. "The Hospital as a Matrix Organization." Hospital Administration 17 (Fall 1972): 8-25.
- Neuhauser, Duncan. "Cost Effective Clinical Decision Making and the Medical Care Manager." Hospital and Health Services Administration 25 (Summer 1980): 55-61.
- O'Donovan, Thomas R. "The Department Head and Health Care Delivery." Journal of Nursing Administration 6 (January 1976): 32-36.
- Osterhaus, Leo B. "System Concepts for Hospitals." Hospital Administration 14 (Fall 1969): 57-66.
- Ouchi, William G. "The Relationship Between Organizational Structure and Organizational Control." Administrative Science Quarterly 22 (March 1977): 95-100.
- Reece, David, Boissoneau, Robert, and Walters, Eric. "Division Management System Replaces Unit Management." Hospital Topics 57 (January-February 1979): 12-16.
- Reinhart, Uve. "Manpower Substitution and Productivity in Medical Practice." Health Services Research 18 (Fall 1973): 200-227.

- Reece, David, Boissoneau, Robert, and Walters, Eric. "Division Management System Replaces Unit Management." Hospital Topics 57 (January-February 1979): 12-16.
- Reinhart, Uve. "Manpower Substitution and Productivity in Medical Practice." Health Services Research 18 (Fall 1973): 200-227.
- Ross, Austin. "Vertically Linked Organizations Hold Challenges and Opportunities." Hospitals 53 (16 January 1979): 67-72.
- Rostowsky, Richard D. "Decentralization: Innovation in Management." Hospital Topics 56 (September/October 1978): 14-16.
- Rowen, Thomas D. Howell, Douglas C. and Gugliotti, Jan A. "The Pros and Cons of Matrix Management." Administrative Management 41 (December 1980): 22-24.
- Rushing, William. "Differences in Profit and Nonprofit Organizations: A Study of Effectiveness and Efficiency in General Short Stay Hospitals." Administrative Science Quarterly 19 (December 1974): 474-484.
- Sayles, Leonard R. "Matrix Management: The Structure With A Future." Organizational Dynamics 5 (Autumn 1976): 2-17.
- Sills, Grace M. "Nursing, Medicine, and Hospital Administration." American Journal of Nursing 76 (September 1976): 1432-1434.
- Sloan, Frank A. "The Internal Organization of Hospitals: A Descriptive Study." Health Services Research 15 (Fall 1980): 203-228.
- Smith, David. "Organizational Theory and the Hospital." Journal of Nursing Administration 11 (May-June 1972): 19-24.
- Somers, June B. "Information Systems" The Process of Development." Journal of Nursing Administration 9 (January 1979): 53-58.
- Walker, Arthur H. and Lorsch, Jay W. "Organizational Choice: Product Versus Function." Harvard Business Review 46 (November-December 1968): 129-139.
- Werner, Bryan. "Unit Service Management." Hospital Topics 57 (November-December 1979): 16-17.
- Whalen, P.J. "Unit Manager and Nurse Supervisor: A Program for Team Building." Hospital Topics 55 (July-August 1977): 21-25.
- Wright, Norman H. "Matrix Management." Management Review 68 (April 1979): 58-61.
- Yunker, Robert. "Organizational Alternatives for Project Managers." Management Review 66 (November 1977): 46-53.

END

DATE

FILMED

9-88

DTIC